

Health Care News

©2001 The Heartland Institute

The Monthly Newspaper for Health Care Reform

Vol. 1 No. 4 - July 2001

MSAs for Everyone
page 4

Kentucky Gets
New HIP page 5

Hawaii Reconsiders
Privacy Law page 6

NJ Health Insurance
Disaster page 9

How Much Should We
Spend? page 13

CarCare and Medicare
page 16

Attention Focuses on Tax Credits

BY JAMES FROGUE

Representatives Richard Arney (R-Texas) and William Lipinski (D-Illinois), along with 23 cosponsors from both sides of the aisle, introduced the Fair Care for the Uninsured Act of 2001 (H.R. 1331) on April 3, 2001. The plan would create refundable tax credits of \$1,000 per individual, \$2,000 per married couple, and up to \$3,000 per fami-

ly to someone in a 30 foot hole." But in fact, credits of that size can help many families afford coverage—even more so if they are combined with assistance or tax credits at the state level, such as Colorado's recently enacted \$500 credit.

Survey Evidence

According to a recent survey conducted by eHealthInsurance Services, Inc., many good insurance products would be available to families who are eligible for tax credits. The survey looked at the most recent 20,000 approved applications for policies sold through eHealthInsurance.com, the largest online broker of individual health insurance in America. Among the survey's findings:

- **Policies are affordable.** Of the 20,000 policies examined, 15,000 fell within 75 percent to 100 percent of the tax credit amounts proposed in Arney/Lipinski's H.R. 1331.
- **Quality coverage is available.** Of the 20,000 policies, 93 percent were for a health maintenance organization (HMO) or preferred provider organization (PPO) product. Of the HMO products, 80 percent had no deductible; of the PPO products, 71 percent had a deductible less than \$1,000.
- **Individually purchased plans are widely available.** The 20,000 approved

TAX CREDITS continued on page 7

"Tax credits would allow families to select their own coverage and change plans if they became dissatisfied."

ly for the purchase of health insurance. The bill joins other legislative proposals, including one from President George W. Bush, that also offer refundable tax credits to help families buy health insurance.

Opponents commonly argue tax credits do not offer enough assistance to people to purchase coverage. As one critic put it, a \$1,000 tax credit to help an individual buy health insurance is like throwing a "10 foot

Saving Lives, Making Money

Drug company profits aren't a problem—they're the solution

BY MERRILL MATTHEWS JR., PH.D.

Complaints about prescription drug prices have escalated in recent months. Critics contend drugs cost too much and point to drug company profits as the reason why. They also claim the pharmaceutical industry is our nation's most profitable, and that price controls would make drugs more affordable—especially for seniors—as they appear to be in Canada and some other

developed countries.

As is true in most public policy debates, the issues are far more complex than the critics would make them out to be.

Most Profitable Industry?

The pharmaceutical industry, on the whole, is profitable. But some drug companies lose money, and many non-drug companies make more than drug manufacturers do.

The profitability claim comes from *Fortune* magazine's annual survey of the

SAVING LIVES continued on page 11



Dr. Vern Cherewatenko offers patients a discount on services if they pay cash instead of going through an insurance company. He offers the savings because eliminating the insurance company cuts down on his overhead costs. Photo/Harley Soltes - Seattle Times

The Case for Managed Care

BY STUART A. WESBURY

If your approach to analyzing the health care system is through anecdotes, this article is not for you. We will not discuss Aunt Hilda's latest problem with her insurance company. We will not examine Grandpa's hip replacement at his HMO.

Health care analysis using anecdotes

would require 280,000,000 individual case reviews. Neither time nor the nation's paper supply allows such an approach.

This series will look at managed care from a macro perspective, the only way to understand managed care . . . or the entire health care system, for that matter. Individual cases come later. Remember, medical students do not start their education with the performance of brain surgery. There is much to be learned before a student can deal with a specific patient.

Thank you for reading on.

MANAGED continued on page 17

INSIDE

2 Patients Rights?
3 The Pulse
7 Missouri Debates CON

8 State Legislative Update
14 The "Do Something" Shuffle
15 The Galen Report

Health Care News

EDITORIAL OFFICES

The Heartland Institute

19 South LaSalle

Suite 903

Chicago, Illinois 60603

312/377-4000 voice • 312/377-5000 fax

email think@heartland.org

PRESIDENT

Joseph L. Bast

PUBLISHER

Nikki Saret

EDITOR

Diane Carol Bast

MANAGING EDITOR

Conrad F. Meier

ASSISTANT EDITORS

Greg Scandlen

Merrill Matthews

CONTRIBUTING EDITORS

Grace-Marie Arnett, Twila Brase

Bob Corkins, Dr. Miguel A. Faria

Gerry Smedinghoff

CARTOONISTS

Mike Shelton

Chuck Asay

DESIGN AND PRODUCTION

Kevin Fitzgerald

Jennifer Beranek

BOARD OF DIRECTORS

Joseph Bast, Robert Buford, Paul Fisher

James Fitzgerald, Dan Hales

William Higginson, James L. Johnston

Roy E. Marden, David H. Padden

Frank Resnik, Leslie Rose, Robert Russell

John Skorburg, Dave Thornbury

Herbert J. Walberg Ph.D., Lee H. Walker

Health Care News is published

12 times per year by

The Heartland Institute.

Subscriptions are free to

U.S. residents and \$24 per year

for foreign residents. Order online

at www.heartland.org. Heartland

is a nonprofit and nonpartisan public

policy research organization serving

the nation's federal and state elected

officials, journalists, Heartland Members,

and other opinion leaders. Its activities

are tax-exempt under Section 501(c)(3)

of the Internal Revenue Code.

© 2001 The Heartland Institute. Nothing in this issue of Health Care News should be construed as reflecting the views of

The Heartland Institute, nor as an attempt to aid or hinder the passage of any legislation.

Patients' Rights? Try Prisoners' Rights

BY JAMES FROGUE

It may sound healthy, this debate we're hearing in Washington over a "Patients' Bill of Rights." But it's like listening to prisoners clamor for better food and more yard time. No matter what the outcome, they're still prisoners. What they should be angling for is early parole.

That's why it was disappointing to hear President George W. Bush outline what he wants to see in a Patients' Bill of Rights. Yes, his vision differs slightly from the leading congressional proposal sponsored by his former presidential rival, Sen. John McCain (R-Arizona), and Rep. Greg Ganske (R-Iowa). But both plans largely preserve the status quo and don't allow the prisoners—that is, Americans with private health insurance—any opportunity for freedom.

Who Benefits from Bill of Rights?

More than 42 million Americans lack health insurance today, mostly because they work for small firms that don't offer it, and they can't afford to buy it themselves. A Patients' Bill of Rights won't do them any good.

What about those who do have health insurance? The Patients' Bill of Rights does absolutely nothing to give these people a greater choice of health plans. More than 90 percent of them get coverage through their employers. Less than half have any choice among plans, and even then the "choice" is typically from a very short list chosen not by them but by their employers.

If they're not satisfied with their insurer for any reason, that's tough. Ask yourself: When's the last time your employer asked for your input? Essentially, workers are forced to buy health insurance through their employers or go without coverage.

Given this limited choice, it should come as no surprise that a lot of people are dissatisfied with their employer-sponsored plans and frustrated by the fact they can't do anything about them.

Many have complained to their congressman about their HMOs, demanding "something be done." A Patients' Bill of Rights may be "something," but it addresses the wrong issue.

The question shouldn't be: How do we make employer-provided health plans more responsive? The question should be: How can we reform a system that makes it all but impossible to get affordable health insurance other than through your employer?

Alternatives to Bill of Rights

Most Americans wouldn't think of letting their employer choose insurance policies for their automobiles or their homes. So why should they let their employers choose a health insurance plan for them and their families?

If workers had a real choice, insurance companies would have to compete customer by customer for business. Insurance companies would become more

responsive—without a Patients' Bill of Rights.

Two alternatives to what Congress and the administration have proposed would finally give American workers real decision-making power in health care.

One approach would let employers offer "defined contributions"—a specific amount individuals could use to buy coverage from the health plan of their choice.

D-C plans work much like the 401(k) contributions many employers now make. Employers would perform the clerical duties and leave the important decisions to their employees. Employers merely send a check—which includes their contribution plus any employee contribution that is withheld from their paychecks—to the insurance company chosen by each employee. Employees get the coverage they want, and employers no longer spend even one minute shopping for insurance.

A second alternative would make refundable tax credits available to workers whose employers don't offer health insurance. Doing so would give lower-income workers, who represent most of the uninsured, access to the same level of health benefits typically offered to higher-income workers.

"Most Americans wouldn't think of letting their employer choose insurance policies for their automobiles or their homes."

Power to the Patients

The credits also would give them the leverage a Patients' Bill of Rights is meant to provide. Employees who buy plans directly from insurers become party to the contract. If insurers don't live up to the contract, employees can sue. But by its very nature, an employee-controlled system of health care would make the lawsuit course of action far less necessary.

Say you went to a restaurant and received lousy service or a bad meal; you wouldn't sue unless you ended up in the hospital. Instead, you'd vow never to return to that restaurant, and you'd tell your friends to steer clear as well.

In our present employer-based health-insurance system, most Americans have no choice but to continue eating at the restaurant that made them sick. No wonder they see the courts as their only option. Wouldn't it be nice if they could just eat somewhere else?

James Frogue is a health care policy analyst at The Heritage Foundation, a public policy research institute.



The Pulse

A review of free market health care reform in the news

The editor of *Employee Benefit News*, David Albertson, notes it is difficult to tell if employers are really interested in defined contribution, or if the interest is just wishful thinking on the part of D-C proponents. Albertson's article reflects arguments made by Paul Fronstin in a recent *EBRI Issue Brief*—especially how D-C is a lot tougher to do in health than it was with retirement programs.

According to Albertson, a recent EBN-Hay Group study shows only 8 percent of employers are "actively considering" moving to D-C. If employers were really interested in moving towards a more consumer-driven system, Albertson writes, they would start by "lobbying in favor of legislative and regulatory changes needed to make flex plans more valuable."

What Albertson misses is that defined contribution is not primarily a political/legislative issue. It is a market

the health care business, but it's not a core competency for us." He said, "we want to convert our health care contributions back to pay and put them where employees can use them best."

Source: <http://www.benefitnews.com/health/detail.cfm> http://www.benefitnews.com/subscriber/01_04_15/health2.htm

Problems Aplenty

The *Cincinnati Business Courier* reports the area's "growing uninsured population is pushing our local health care system to the breaking point." The article chronicles problems with health care providers trying to serve more uninsured, with fewer resources. It cites a number of individuals who can't afford to keep paying premiums and are facing devastating medical conditions. It mentions a dental clinic that has a waiting list of 3,000 people, and employers who can't afford to pay for comprehensive benefits.

The story doesn't suggest solutions, but clearly refundable tax credits, MSAs, and employers who are able to contribute what they can afford would all help.

Source: <http://cincinnati.bcentral.com/cincinnati/stories/2001/04/23/story1.html>.

Princeton Likes Parents

Uwe Reinhardt lashes out at defined contribution proposals in an article in the *Health Forum Journal*. He seems particularly annoyed that the "health care conference circuit" is "abuzz" with such "visions." While Reinhardt agrees the idea is attractive "in the world of theory," he wishes to enlighten us to "another world" in which "employers and employees dwell."

According to Reinhardt, in that other world—with which Princeton economics professors are so intimately familiar—workers prefer to have their employers treat them like parents treat children (the Parental Model). Employees will reject the "Mature Adult Model," he says, because it is "much more radical."

"Employees will insist that the approach remain embedded in the 'parental' model of managed competition to which they have been accustomed for half a century," Reinhardt predicts.

Source: <http://www.healthforumjournal.com/asp/ArticleDisplay.asp?PubID=7&ArticleID=144>

The Galen Conference

The Galen Conference on Transformative Change through Market-Driven Health Care conference was a big success by any measure. The attendance was strong with an interesting mix of people. The presenters were terrific, and there was a lot of media presence. Most of the initial media reports centered on Tom Scully's first speech as HCFA Administrator, but there were between five and 10 reporters on hand for the whole day, so look for additional articles in the trade press.

Scully's remarks were written up in the



Washington Post, *New York Times*, and many other papers. The *Post* emphasized his intention to issue comparative performance data on providers, though the article said he was going to "rate" providers, which he did not say. The

death—whew!

Source: For more information contact Susan Busch (763/614-2126, or susan.busch@ebenx.com)

Little Mention by the Media

There has been little mention in the press about President George W. Bush's budget proposal to allow up to \$500 of an individual's unspent FSA account to rollover each year. Writing in *Business Insurance*, Jerry Geisel reports the administration would allow employees to cash-out and pay taxes on the balances during the course of the year, or roll year-end balances into an MSA, 402(k), or into next year's FSA.

Source: <http://businessinsurance.com>

Here's A Must-Read

If you're at all interested in the concept of defined contribution health insurance, you must get your hands on . . . and read . . . a new publication from the Evergreen Freedom Foundation, titled *Primer on Defined Contribution Health Plans: Enabling Employee Choice—A Practical Resource for Employers*. The publication's lead author, and manager of the Defined Contribution Project at Evergreen, is Stephen Barchet, MD. Lynn Harsh, executive director of Evergreen, provided overall direction from inception to publication.

Source: <http://www.effwa.org>

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis located in Dallas, Texas. To sign up for his free weekly e-newsletter send an email to: HealthPolicyWeek-subscribe@yahoo.com. Scandlen can be contacted at GMScandlen@aol.com.

"Defined contribution is not primarily a political/legislative issue. It is a market issue. D-C doesn't need legislation, it needs an attitude adjustment by employers."

issue. D-C doesn't need legislation, it needs an attitude adjustment by employers, as is reflected in another article in the same issue of *Employee Benefit News*.

Craig Gunsauly reports on a recent meeting held by the Washington Business Group on Health. He quotes WBGH President Mary Jane England as saying, "(Employees are) going to have to partner more with employees so they can take more responsibility for their health care"—in other words, employers need an attitude adjustment, need to recognize the role employees should play in their own health care decision making.

Jean Wodarczyk of PricewaterhouseCoopers also addressed the meeting. She predicted interest in D-C health plans would remain high among employers, noting several factors are contributing to that trend: use of the Internet for transactions (not just information), the popularity of D-C retirement plans, rising health care costs, and the growing popularity of benefits outsourcing.

Gunsauly's article also mentions a presentation by Larry Becker, director of benefits at Xerox. It seems Xerox has not backed away from its intention to move toward a "total pay" compensation system, despite press reports to the contrary. Becker says the company is "not exiting

"According to Reinhardt, workers prefer to have their employers treat them like parents treat children (the Parental Model)."

Times was more interested in his hope to increase the numbers of Medicare beneficiaries enrolled in Medicare+Choice plans (though he said he hates the name "Medicare+Choice").

Editor's note: See page 14 for Sam MacDonald's contrarian view, and page 15 for the Galen Institute's perspective.

An Odd Duck

Dr. Alain Enthoven, the father of "managed competition," has joined the Board of eBenX. John Davis, president of eBenX, calls Enthoven "one of this nation's health care visionaries." And Enthoven says eBenX's technology is key to "the vision of managed competition that emerged from the Jackson Hole Group." Man, talk about your kiss of

MSAs for Everyone

BY JOHN C. GOODMAN

The idea behind Medical Savings Accounts (MSAs) is that individuals are able to own and control some of their own health care dollars. Instead of turning all the money over to an employer or insurance company, some of the funds are placed in an account from which patients pay directly for medical services. Further, individuals ultimately get to keep any MSA funds they do not spend.

MSAs work well for those who have them. So well, in fact, that everyone should have one.

Advantages of MSAs

Medical Savings Account plans have proved remarkably popular among the small number of people who currently have one. Employers like them because they give employees incentives to control costs. Employees like them because they get to keep any funds they do not spend. And employees can make their own decisions about the trade-off between money and health care services, rather than have those decisions made for them by an impersonal bureaucracy.

Doctors like MSAs because they can practice medicine as agents of their patients, rather than as agents of employers or insurance companies. When doctors are free to put the welfare of patients first, patients are likely to get better health care.

Tax Law Discourages MSAs

So why doesn't everyone have an MSA? The problem is the tax law. Employer premium payments are excluded from employees' taxable income—a tax subsidy that can be worth 50 cents on the dollar for many middle-income employees. On the other hand, since employer deposits to MSAs are taxed at the time the deposit is made, Uncle Sam takes as much as half the money the employer tries to deposit. In this way, the tax law encourages a system under which we give all our health care dollars to a third-party payer.

An exception to the tax law is a federal pilot program established in 1996. The program allows tax-free deposits to MSAs for the self-employed and employees of small businesses. But because of unfriendly rules and restrictions, only a fraction of people who are eligible have actually enrolled in an MSA plan.

One problem is that the law allows a maximum of 750,000 MSA enrollees. Large insurers thus lack the incentive to market an MSA product the way they marketed Roth IRAs. Another problem is the severely restrictive rules governing deductibles. For example, the law requires families to have a \$3,000 across-the-board (covering all services) deductible, regardless of how much is in the family's MSA.

As a result of such restrictions, only about 100,000 households actually have a tax-free MSA today.

MSAs in South Africa

In contrast to the U.S. experience, MSAs are flourishing in South Africa. Beginning in the early 1990s and continuing through-

out the Nelson Mandela regime, South Africa had a relatively free market for health insurance. HMOs, PPOs, MSA plans, and virtually every other type of health plan available in the U.S. have been competing on a level playing field in South Africa for almost a decade. The result: MSA plans have captured more than half the market for private insurance.

Why have MSA products been so successful in South Africa, while languishing in the United States? The answer is that South African MSAs are the product of market forces, not government decree. For example, there is no law stipulating how high or how low the deductible must be. In fact, in a typical plan there are different deductibles for different services.

“[Flexible MSAs/FSA accounts] would give people more access to health care, more choice, and better protection than most proposals for a patient's bill of rights.”

Under one popular South African plan, patients face no deductible when they enter a hospital, on the theory it is difficult for patients to exercise choice in that setting. For outpatient care, where patients exercise much more discretion, the deductible is set at about \$1,200. The deductible drops back to zero for certain drugs, especially in cases where failure to take them could lead to more costly care later on.

A Near MSA

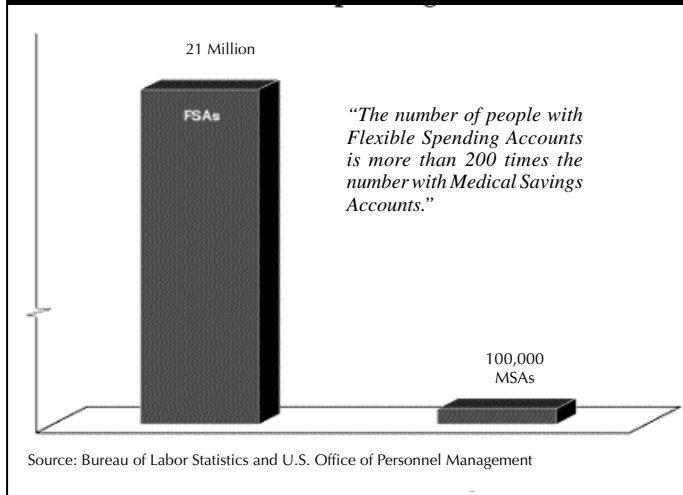
Millions of U.S. workers already have access to a tax-free account that has all of the flexibility of MSAs in South Africa. These are called Flexible Spending Accounts (FSAs).

FSAs work like this: At the beginning of the year, employees agree to monthly, pretax payroll deductions deposited into their FSA. During the year, employees can use their accounts to pay for medical services not covered by their health insurance plan.

FSAs allow direct purchase of medical care and receive the same breaks under the tax law as employer payments of health insurance premiums. Further, the number of people using FSAs is more than 200 times the number with a conventional MSA.

The problem is that FSA accounts are governed by a use-it-or-lose-it rule. Any money left in the account at year-end is forfeited. So instead of encouraging people to spend prudently, end-of-year FSA balances encourage people to search for ways to spend money—on more expensive eyeglasses, more diagnostic tests, or other services the IRS considers “health care.”

Number of People Using Accounts



Turning FSAs into Flexible MSAs

A small change in the current law would turn FSAs into flexible MSAs—exactly what's needed:

- Employees could make pretax deposits to the account regardless of the type of health insurance they have, just as they can under current law.
- Employers could make FSA deposits on behalf of their employees, as they can under current law.
- Unlike the current use-it-or-lose-it restriction, unused FSA balances would roll over tax-free.
- Beyond a 12-month insurance period, FSA account owners could move their deposits to an account managed by any qualified institution.
- Funds could be subsequently withdrawn for non-medical purposes, provided income taxes are paid.

These flexible MSA accounts would create a new option without taking away any current option. Some may be concerned that employees would use their accounts as a way to augment tax-deferred savings. Such an outcome is not bad, but it could be prevented: Simply limit the annual IRA contribution plus flexible MSA rollover to the maximum allowable IRA deposit (currently \$2,000 per person).

Personal, Portable, and Affordable

The new FSA/flexible MSA accounts would address a number of the problems people currently face in the health care system. These accounts would be:

Personal. Unlike employer-based health insurance, the new accounts would belong to the individual, not the employer. Account balances would be part of a person's estate at death.

Portable. Since the new accounts would belong to the individual, they would move with employees from job to job and could be used to pay health insurance premiums between jobs.

Affordable. Contributions to the new accounts would be strictly voluntary, and they could easily be integrated with the employee's personal savings plans.

This proposal has several additional advantages:

- Enrollees in HMOs and other managed care plans would be able to make FSA deposits and use the funds to pay for doctor visits, diagnostic tests, and other services not paid for by their health plan.
- Participants in Point of Service plans could use their FSA funds to pay fees charged by non-network physicians.
- Employers and insurers would have much more flexibility in designing plans; for example, they could provide first-dollar coverage for such services as preventive tests and high deductibles for other services without jeopardizing the ability of the insured to have an FSA.
- A casualty insurance approach—one that pays fixed fees for treatments—would become more viable: If the fixed fee proved insufficient, people could use their FSA funds to pay the difference.

Conclusion

Using FSAs as MSAs would change the way the health care market responds to the perceived deterioration of health care quality that has emerged with the growth of managed care. Such accounts would give people more access to health care, more choice, and better protection than most proposals for a patient's bill of rights.

John C. Goodman is president of the National Center for Policy Analysis.

PLEASE REPRINT THIS ARTICLE!

Reprint permission for **all** articles appearing in this publication is hereby granted provided credit is given to the authors and to this publication. Elected officials and leaders of civic, grassroots, and business groups are specifically encouraged to reprint articles in their newsletters and magazines. Electronic versions of most articles can be found at www.heartland.org. Before editing for length or content, please call Lee Lerner at 312/377-4000. Please send tearsheets to The Heartland Institute, 19 South LaSalle Street #903, Chicago, IL 60603.



Samantha Eades (left) and Darlene Shelton, both of Lexington, Kentucky, talk with Janice Nieman of Insurance Care about disability insurance. Photo/David Perry-Lexington Herald-Leader

Kentucky Offers New HIP

Colorado legislators stabilize funding, increase benefits for that state's HIP

BY CONRAD F. MEIER

Kentucky Access, the state's new high-risk health insurance pool, has enrolled 164 Bluegrass State residents who previously were unable to afford or obtain health insurance, typically due to a pre-existing condition.

The program, which went into effect in January, is "on target" and currently has 300 pending applications. State officials say all are "likely to be approved."

According to a news report in *Health Policy As It Happens*, Janie Miller, the state's Insurance Commissioner, does not expect to see dramatic increases in the HIP's enrollment until October or November, when private health plans typ-

ically enter their renewal period. About 1,200 are expected to enroll by the end of the year, with up to 5,000 expected in future years.

"Twenty-eight states now operate risk pools that offer comprehensive insurance for people who typically have been denied private insurance due to a preexisting condition or chronic illness."

The state is marketing the program in *Kentucky Living*, a local magazine reach-

For more information...

WWW See "Extending Affordable Health Insurance to the Uninsured," *Heartland Policy Study* No. 91, issued in August 1999 and available on the Internet at <http://www.heartland.org/studies/meier-sum.htm>.

Breaking health care news can be found on the *Health Policy as it Happens* Web site at <http://www.kaisernetwork.org>.

ing 400,000 homes every month. In addition, an aggressive advertising effort includes information posted at pharmacies and attached to prescription bags. According to Miller, the state is offering insurance agents and brokers a \$50 referral fee for each individual who successfully joins the program.

Kentucky Access is a cooperative effort between state government and private-sector insurance, an arrangement currently available in 28 states. The program represents a partial solution to years of failed state government-run health care plans in Kentucky. The state's single-payer plan eventually drove out competition, leaving just two insurers serving the Kentucky market. Insurance premiums increased dramatically, contributing to the growing uninsured rate in the state.

By enrolling Kentuckians with known, high-risk medical conditions in a separate insurance pool, the state hopes to encourage private insurance companies to return to the state marketplace.

Colorado Has New HIP Funding

CoverColorado gained an added measure of stability with new legislation signed on May 5 by Gov. Bill Owens (R). The measure provides more reliable funding for the state's high-risk health insurance pool, implementing a broad-based insurance industry assessment instead of relying solely on general revenue appropriations to cover plan claims and administrative costs.

The law also makes several improve-

ments to CoverColorado benefits: It increases the maximum benefit coverage under the program from \$500,000 to \$1 million, comparable to programs in most other states; allows for coverage of dependents of eligible individuals; and makes the risk pool the state's alternative for access guarantees in the individual market under HIPAA, the federal health insurance portability law.

Twenty-eight states now operate risk pools that offer comprehensive insurance for people who typically have been denied private insurance due to a pre-existing condition or chronic illness. People enrolled in the programs pay a premium somewhat higher than what is standard in the state's insurance market, but the premium is capped by law at a specified

"High-risk pools not only serve people with a proven need for insurance protection, but also help shield insurance companies from the expense of insuring persons with predictable, high-cost medical needs."

percentage above standard.

Subsidies are inherent in the nature of high-risk pools, as insurance premiums cannot be set sufficiently high to cover all the program costs. In 25 of the 28 states with HIPs, assessments on the insurance industry are the principal mechanism for funding the subsidy, often with some level of tax support by the state.

High-risk pools not only serve people with a proven need for insurance protection, but also help shield insurance companies from the expense of insuring persons with predictable, high-cost medical needs. HIPs accomplish the social goal of assuring access to quality medical care for those who need it, without the disruptions and negative side effects caused by regulation of the insurance industry.

Support Health Care News! Become a Heartland member and donor.

Health Care News is published by The Heartland Institute, an independent nonprofit organization founded in 1984. Contributions are tax deductible under Section 501(c)3 of the Internal Revenue Code.

Membership	Additional Contribution	
☐ \$29	☐ \$1,000	☐ \$100
☐ \$49	☐ \$500	☐ \$50
	☐ \$250	☐ \$25
	☐ Other _____	

☐ My check in the amount of \$_____ is enclosed.

☐ Charge \$_____ to my ☐ Visa ☐ MC ☐ Am Ex

Account Number _____

Expiration Date _____

Signature _____

Name _____ Home Phone _____

Title•Company _____ Work Phone _____

Address _____

City•State•Zip _____

☐ Please send me additional information about The Heartland Institute.

☐ Please send me information about advertising in HCN.

Please return form to The Heartland Institute, 19 South LaSalle Suite 903, Chicago, Illinois 60603; fax 312•377•5000.

HCN07

Hawaii Lawmakers Reconsider Privacy Law

Special task force convened to determine how—indeed whether—1999 measure should be revamped

BY CONRAD F. MEIER

Mass confusion has forced Hawaii lawmakers in the 2001 legislative session to put a medical records privacy law on hold and convene a special task force to review the law and recommend changes. The task force's report was expected by July 1.

In 1999, the state legislature had passed "The Privacy of Health Information Act," a medical records law mandating that medical information could be exchanged without patient permission only among doctors, hospitals, and health insurance companies. Others seeking private medical information must first obtain a signed release from the patient. The legislation provides civil and criminal penalties for violations.

However well-intentioned, the law has presented a compliance nightmare for organizations and individuals handling medical records.

State-Federal Conflict

One issue here is the conflict between state law and the July 1 effective date of a new federal law, the Gramm-Leach-Bliley Act. Many Hawaii legislators have called for repeal of the state-specific law, saying the federal measure offers better protection for the confidentiality of medical data contained in records.

The Gramm-Leach-Bliley Act, primarily a banking bill, sets standards for handling all private information. Title V of the act requires development and disclosure by all financial institutions of privacy policies governing the sharing of non-public personal information with affiliates and third parties. Specifically, the measure

- requires consumers receive notice of their right to "opt-out" of sharing of non-public personal information with nonaffiliated third parties; only certain limited exceptions are allowed.
- clarifies that the disclosure of a financial institution's privacy policy is required to take place at the time of establishing a customer relationship, and then not less than annually during the relationship.
- extends the time period for completion of a study on financial institutions' information-sharing practices from 6 to 18 months from date of enactment.
- requires that regulators issue rules for the disclosure of institutions' privacy policies within six months of the date of the bill's enactment. The rules become effective six months after they are issued, unless the regulators specify a later date.
- assigns authority for enforcing the subtitle's provisions to the Federal Trade Commission and the federal banking agencies, the National Credit Union Administration, and the Securities and Exchange Commission, according to their respective jurisdictions, and provides for enforcement of the subtitle by the states.

Too Big a Hurry

The Hawaii measure has presented problems in part because the legislature was in too great a hurry to adopt it. Hoping to guarantee more protection for patients than had been available before the measure was passed, lawmakers instead produced a confusing and difficult-to-implement patchwork of differing laws.

According to George Bussey, medical director for Queen's Health Plans and a member of the task force charged with reviewing the Hawaii law, the state legislators were not given an opportunity to review the federal law before it was passed, and thus had no chance to evaluate how federal law would impact state law. A similar difficulty may arise when the Bush administration considers changes to HIPAA privacy regulations set for implementation in 2002.

To cope with the confusion caused by the 1999 law, several bills were introduced in the current Hawaii legislative session.

House Bill 362, which requires the state insurance commissioner to adopt the regulations set forth in the Gramm-Leach-Bliley Act, was unanimously approved . . . but it remains far from clear just what rules will be adopted and who will enforce them.

Hawaii Not Alone

"States continue to enact privacy legislation that is either in conflict with or more stringent than the federal regulation," notes Representative Jim Greenwood (R-Pennsylvania) in the March 2001 issue of *Roll Call*.

Like Hawaii, efforts at privacy legislation in California, Maine, and Minnesota offer examples of the potential harm resulting from a rush to protect privacy.

A modified Minnesota privacy law prevented the Mayo Clinic, the country's most prestigious medical institution, from conducting life-saving research. Minnesota's law required specific authorization for the use of medical data needed to conduct medical outcomes studies. It took Mayo years and millions of dollars to adapt its systems and processes to the changed regulatory environment.

Follow the Money

For the Hawaii Medical Service Association (HMSA), the state's largest insurance company, the jury is still out on how the state health privacy bill, the Gramm-Leach-Bliley Act, and HIPAA will mesh and ultimately affect the company. One thing is certain: Compliance will cost a lot of money.

"Hoping to guarantee more protection for patients than had been available before the measure was passed, lawmakers instead produced a confusing and difficult-to-implement patchwork of differing laws."

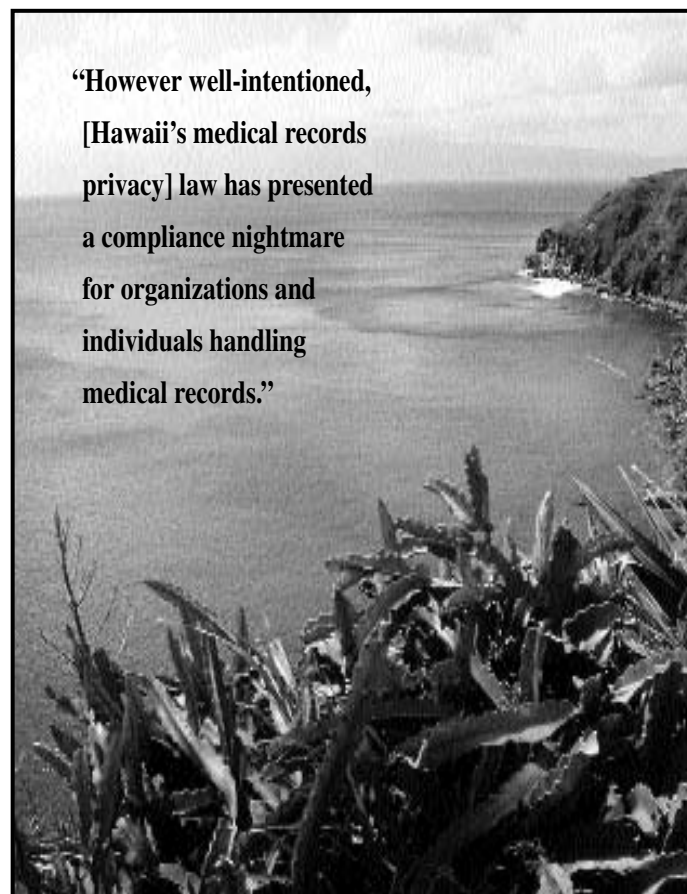
Cliff Cisco, HMSA vice president, told *Pacific Business News*, "The company has spent a nominal amount on costs related to implementation of the state's privacy law, mostly related to communication. But far more worrisome for the company is how much the federal law will eventually cost to implement. We have rough numbers, but it will be significant."

Richard Meiers, president of the Healthcare Association of Hawaii, estimates privacy implementation measures could cost more than Y2K conversion measures did. Meiers is on record as estimating Hawaii's cost at \$276 million. Nationally, the Department of Health and Human Services has put privacy implementation costs at \$17.6 billion; Blue Cross-Blue Shield estimates \$40 billion.

Other Fallout

There has been little discussion in the mainstream press of the negative consequences of poorly crafted privacy legislation, including:

- the increased paperwork privacy regulations impose on already over-burdened physicians and hospital staff;
 - possible conflicts between state and federal laws;
 - the potential harm to patients when access to medical history and treatment data is restricted; and
 - the slowing of medical progress—ultimately affecting human health and life-spans—caused by increasing the regulatory burden on medical research. "Better, more efficient ways of treating patients are also likely to remain untested," warns Greenwood in his *Roll Call* article, "because of difficulties in sharing data on clinical trials among different states."
- These are important issues, and they make clear that medical privacy is not the black-and-white, good-or-bad issue it is often made out to be. Complex problems call for carefully thought-out solutions; Hawaii offers just one example of what can happen when legislators are too quick to jump on a bandwagon.



"However well-intentioned, [Hawaii's medical records privacy] law has presented a compliance nightmare for organizations and individuals handling medical records."

Missouri Debates Future of Certificate-of-Need

Launched more than 20 years ago, law has "outlived its usefulness," critics says

BY CONRAD F. MEIER

At the end of 2001, some elements of Missouri's Certificate-of-Need (CON) law are set to expire. The looming deadline has opened debate in the state about the continuing need for the program, which first went into effect more than 20 years ago.

Effective January 1, 2002, several types of medical services—including acute, rehab, psychiatric, or other hospitals (except long-term acute care), freestanding hemodialysis units, and ambulatory surgery centers—would no longer require review under CON. Unchanged by the sunset, CON will continue to review such facilities and equipment as nursing homes and residential care facilities, long-term care beds in acute care hospitals; new hospitals; and major medical equipment costing \$1 million or more.

The purpose of the CON statute, according to its "purpose and structure" provision, "is cost containment through health cost management, assurance of community need and the prevention of unnecessary duplication of health care services. CON is based on a goal of public accountability through public review of proposed health care services, value promotion and negotiation among competing interests."

Tom Holloway, director of government relations for the Missouri State Medical Association, told the *Kansas City Business Journal*, "the Certificate of Need program has outlived its usefulness. It doesn't do anything but stifle competition and innovation. It's extremely bureaucratic, and no one relishes having to go through it. It's the people who have existing projects who want it to continue. It helps them keep competition out of their back yard."

Border Conflicts

In the Kansas City area, the debate over renewing the CON law has pitted Saint Luke's-Shawnee Mission Health System against Health Midwest. Repealing the CON program would give Saint Luke's the freedom to expand in Eastern Jackson County, meaning increased competition for Health Midwest.

"For the benefit of the community and to ensure there's a fair and equal playing field for all, CON is in our best interest," Barry Seward, a senior vice president for Health Midwest, told the *Business Journal*. "We should be able to demonstrate to our communities and the state regulatory body that there is a need for a particular program."

Sen. Marvin Singleton (R-Seneca) disagrees, believing the environment fostered by the CON program is more detrimental than deregulation would be. Singleton, a practicing physician, served on the Health Facilities Review Committee, which oversees the CON program, in the early 1990s.

The problem with CON, according to Singleton, "is that it's not based on need but on marketing." Singleton said members of the committee often bowed to political pressure from lawmakers and campaign contributors when voting on CON requests. The end result, he said, has been a disproportionate allocation of resources in certain parts of the state and the protection of monopolies.

"I'm ready to say enough's enough," Singleton said. "What we have right now is unworkable, expensive, and guarantees a monopoly for often inefficient, poor operators of health care facilities."

Kansas City has encountered especially thorny CON-related conflicts because it straddles the Kansas-Missouri state line. In documented cases, health care providers have opted to locate centers on the Kansas side because the state has no CON program. Johnson County, Kansas has become a hotbed of health care activity, boasting several new hospital and ambulatory care centers.

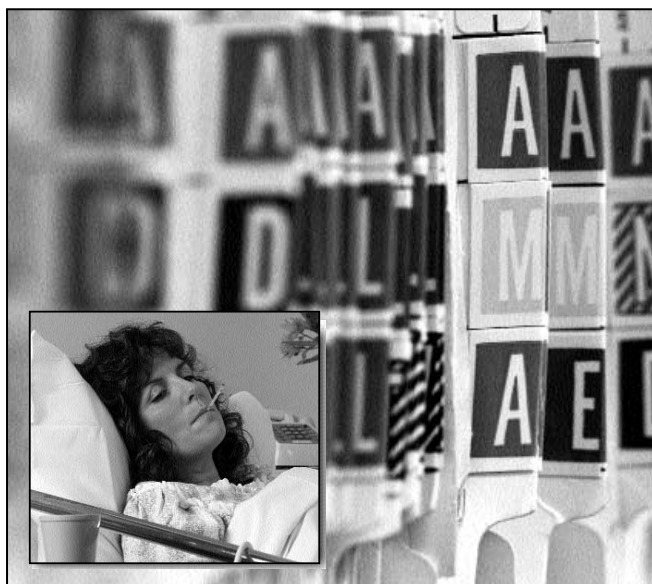
Dr. Charles Rhoades, CEO of the Kansas City Orthopedic Institute, a free-standing surgical center in southern Johnson County, Kansas, never considered building in Missouri because of CON. John Hennessy, executive director of Oncology & Hematology Associates, the largest oncology practice in the Kansas City metropolitan area, said his group launched its effort to build outpatient cancer care centers on the Kansas side of the metro area because of CON restrictions.

Eliminating Competition

CON laws were aggressively adopted by states across the country in the 1970s, in an effort to encourage consolidation of small and presumably inefficient hospitals and reduce expensive duplication of medical services. Since then, empirical research has concluded the laws were effective in slowing the growth in the number of hospital beds in a community. But that restriction on supply did not have the desired effect on health care costs.

"Restrictions may sound good in theory," writes Professor James Henderson in *Health Economics and Policy*, "but one of the unintended consequences of any limits placed on a market is the elimination of competition. Reduced competition leads to market power and market power leads to market failure."

In response to the unintended conse-



TAX CREDITS continued from page 1

policies were from 40 states representing 93 percent of the U.S. population. Covered persons ranged in age from one to 64 years old.

The Problem?

Employer-Based Insurance

America's system of employer-based private health insurance is fraying. Despite last year's small decline in the number of uninsured Americans, uninsurance increased during the 1980s and 1990s and is universally forecast to continue rising. Absent changes in public policy, there could easily be another 10 million uninsured by 2010.

Alternatives to the system of employer-based coverage are needed. Under the current tax code, workers whose employers contribute to their health coverage have that amount excluded from income and payroll taxes. This represents a significant and highly regressive tax break: the higher one's tax bracket, the bigger the subsidy.

The Appeal of

Refundable Tax Credits

Refundable tax credits would address the regressive nature of the current system. The credits would direct assistance to people who need it most—lower-income Americans who receive no subsidies because they are not eligible to participate in an employer's plan. Nearly half of the estimated 42.6 million uninsured pay no federal income taxes, making it essential that the credits be refundable.

The benefits of moving toward tax credits and making coverage more affordable would include the following:

- **The right to sue.** Individuals who

purchase their own health insurance policies have unambiguous legal remedies as the first party to a contract with a health insurance company. These families would not need a Patients' Bill of Rights.

- **The right to choose coverage.** Under the current system, most Americans are at the mercy of their employer when it comes to choosing a health insurance policy. Tax credits would allow families to select their own coverage and change plans if they became dissatisfied. Better service results when customers have options.

- **Portability.** Individually purchased plans could be kept regardless of employer or employment status, providing a consistency of coverage especially beneficial for people with preexisting conditions.

- **Privacy of medical records.** Patients are quite properly concerned about the privacy and security of the information in their medical records. Under a refundable tax credit system, patients purchasing their own insurance policies would have more say over what happens to their medical information.

Conclusion

Allowing refundable tax credits of the amounts proposed in H.R. 1331 would substantially reduce the number of Americans without health insurance. As the eHealthInsurance Services survey shows, individually purchased plans are affordable, contain meaningful coverage, and are widely available. Tax credits would allow more people to take advantage of this burgeoning market.

James Frogue is a health care policy analyst at The Heritage Foundation.

For more information...

WWW

on Missouri's Certificate of Need program, visit the plan's Web site at <http://www.health.state.mo.us/CON/Title.html>. For additional information on CON, use **PolicyBot**, The Heartland Institute's free online research service. Go to www.heartland.org and click on the **PolicyBot** icon, then search on keywords "certificate of need."

A monthly review of state legislative activity

COMPILED AND EDITED BY CONRAD F. MEIER

ARIZONA

As predicted in last month's State Legislative Update, the high-risk pool legislation, formerly on a fast-track for approval, hit a brick wall in the Senate. Senator Susan Gerard strongly opposed high-risk pool legislation while serving in the House of Representatives; she now chairs the Senate Banking and Insurance Committee and remains a powerful opponent.

The plan's funding mechanism is the major sticking point. A proposal to provide start-up funding from the General Revenue Fund did not fare well in the Senate. Insurance companies lobbied hard against the alternative: that they should be assessed to fund the pool, without getting an offsetting tax break in return.

On another matter, lawmakers voted 35 to 20 to kill a prescription drug program that would have provided discounts up to 30 percent for senior citizens whose annual incomes were at or below three times the federal poverty level. The proposal is dead until/unless it's raised again next year.

COLORADO

Small group insurance reform became a significant issue late in the session as House Republicans attempted to pass legislation based on free-market principles. Many Democrats in the state refuse to acknowledge that guaranteed-issue and community-rating rules have resulted in growing problems in the small group market: 20 percent inflation in small group premiums, for example, and a growing number of uninsured. In many rural parts of the state, only two insurance carriers offer viable small group coverage.

House Bill 1319, which establishes the CoverColorado high-risk pool as the HIPAA alternative and could provide some relief to the small group/individual market, may not survive opposition by the legislature's Democrats.

In the "there you go again" department, the Gray Panthers, a left-of-center seniors' group, has begun the effort to bring a single-payer initiative to the ballot for 2002. The proposal, which has been sent to the Legislative Legal Services Division for review, appears to suffer from serious viability problems and constitutional concerns.

FLORIDA

In an effort to control soaring Medicaid prescription costs, Florida is preparing to negotiate its own discounts with pharmaceutical companies. A law recently signed by Governor Jeb Bush allows the state to negotiate rebates in exchange for steering Medicaid beneficiaries in the direction of certain drugs on a preferred list—making Florida the first state to break away from a system of federally negotiated discounts from drug manufacturers.

Florida officials estimate the direct negotiations will

save the state \$214 million a year, about 15 percent of the Medicaid drug budget. Jerry Wells, the state's Medicaid Pharmacy Manager, told the *Wall Street Journal*: "Our budget was getting out of control."

Other states, also facing out-of-control Medicaid costs, may copy Florida's approach after years of relying on the federal government to make discount deals on their behalf.

IOWA

The "clean claims" provision of Senate File 500 bill, similar to mandates popping up in other states, may conflict with federal law, as well as with recommendations made by the Iowa Medical Society.

A "clean" claim is one that is complete: It provides all of the information required on the claim form. The Iowa bill, and its counterparts in other states, require an insurer to pay clean claims in a mandated number of days, typically 30. If the claim is lacking required information, it is not a clean claim and is sent back to the claimant for additional information.

Golden Rule Insurance Company, a managed indemnity insurer (as opposed to an HMO), has pointed out that clean claims legislation forces the small group insurer to deny claims when required information is not available to the claimant before the mandated timeframe has lapsed. Denial of claims is not the intent of the "clean claims" legislation.

MARYLAND

The legislature has adjourned after a very active year of health care policy-making. All three of the bills noted below passed the state House and Senate by unanimous votes.

HB 362 requires the Insurance Commissioner to adopt regulations governing the privacy of consumer's financial and health information according to standards set by the Gramm-Leach-Bliley Act of 1999. That act, primarily a banking bill, also set standards for how private information should be handled. Title V of the act requires development and disclosure by all financial institutions of privacy policies governing the sharing of non-public personal information with affiliates and third parties.

HB 695/SB 457 requires the state to contract with an independent consultant to study the small group market, and how Maryland's regulation of that market compares to regulations in other states.

SB 458 requires insurance companies providing medically underwritten health insurance in the individual market to provide information regarding the availability of the Substantial, Available, and Affordable Coverage (SAAC) Program to anyone denied coverage. SAAC is an unfunded health insurance mandate allowing all comers to get guaranteed-issue insurance whenever they want it. The required notice is similar to those issued in states with high-risk insurance pools.

MISSOURI

The Senate approved a bill allowing direct access to an obstetrician/gynecologist and requiring companies to notify enrollees of cancer screening, provide osteoporosis coverage, and require contraceptives to be included in prescription coverage written by health insurance

providers. Two amendments were added to provide Medicaid coverage for persons diagnosed with breast or cervical cancer, and time limits were removed for receiving prosthetic or reconstructive surgery after a mastectomy.

NEVADA

Governor Kenny Guinn and Assembly Majority Leader Barbara Buckley agreed on a pharmaceutical drug program under which the state will contract with a private insurance company to operate a low-cost prescription program for senior citizens.

The measure has the state paying an annual insurance premium of \$1,280 per participant to the insurance company, which in turn will provide prescription drugs to senior citizens who earn less than \$21,500 a year. Participants will be responsible for a \$10 co-pay for generic drugs and a \$25 co-pay for name-brand drugs. The plan caps out at \$5,000 a year per beneficiary and is expected to enroll almost 6,000 residents.

NEW HAMPSHIRE

Active members of the National Association of Health Underwriters were successful in introducing two bills designed to entice insurers back to the state marketplace. Over the last few years, heavy regulation of the New Hampshire insurance market has forced private insurance companies to abandon the state. The result has been above-average premium inflation due to a lack of competition.

The NAHU bills would allow for the return of medical underwriting in lieu of blanket "guaranteed issue" law. The bills would also create a high-risk insurance pool, to be used for HIPAA compliance as well as covering high-risk or uninsurable medical conditions.

WASHINGTON

A new state program called AWARDS was supposed to make medication for seniors (anyone over 55) more affordable, but upon implementation it appears the program may not be worth the price of admission.

The state program, which costs \$25 a year for family membership and \$15 a year for singles, acts as a "buyer's club" piggy-backed on the purchasing power of the state's Uniform Medical Plan. Governor Gary Locke promoted the plan by saying members could save 12 to 30 percent of the retail pharmacy price.

Many of the drugs commonly used by state seniors, however, cost more through the drug program than they do on the open market. Of the 25 most common prescriptions, just seven were less expensive using the state's discount card. In most cases, free-market discounts at chain or discount drug stores saved consumers more money. The one exception is for patients who fill their prescriptions by mail or over the Internet, an option not available to many seniors.

Sources: The Council for Affordable Health Insurance (CAHI) and its member companies provided information for this State Legislative Update. Contact CAHI at mail@cahi.org, <http://www.cahi.org>. Additional material was provided by the National Association of Health Underwriters, <http://nahu.org/government>, <http://bizjournals.com>, and <http://stateline.org>.

New Jersey's Health Insurance Disaster

Garden State offers painful lessons for reform advocates and state policy-makers nationwide

BY LEE TOOMAN

This is the story of how one state, New Jersey, destroyed its private individual health insurance market in the name of "health care reform." It is a cautionary lesson to elected officials and policy analysts around the country.

New Jersey "Reform"

In the early 1990s, New Jersey embarked on an extensive health insurance "reform." The three principal elements were:

1. Pure Community Rating: Neither age, gender, geography, nor health makes any difference in how much you pay.
2. Year-round Open Enrollment: No one can ever be denied coverage, regardless of current health.
3. Five Standardized Indemnity Plans and One Standardized HMO Plan: No other plans may be bought or sold in this market.

In short, New Jersey politicians and bureaucrats designed a one-size-fits-all solution for their individual health insurance market. Freedom of choice went away. Incentives to buy insurance while healthy went away. Recent high school graduates earning the minimum wage pay as much for health insurance as rich investment bankers living in Ridgewood, New Jersey, mansions.

Since 1995, these "reforms" have caused the number of people with private, individual health insurance to drop from 220,000 to 104,000. This is all the more alarming because the situation in

New Jersey was already terrible. Based on national averages, a state the size of New Jersey should have roughly 750,000 people covered by private, individual health insurance plans.

Why Reform Failed

The New Jersey politicians overlooked one detail: They kept the decision to purchase health insurance optional. Had they made it mandatory, they would have at least forced cross-subsidization. Instead, they doomed the New Jersey individual health insurance market to a classic death spiral.

In a normal, competitive insurance marketplace, people will pay premiums even though they believe it is unlikely they will generate high claims, because they do not want to be without coverage in case they do. The insurer, on the other hand, must collect premiums equitably from everybody in the pool to finance the claims cost of the unlucky few whose claims are far in excess of the premiums they pay. The vast majority of insureds pay more premiums than they have claims, but a few unlucky ones have much higher claims than premiums.

The crucial thing is that the amount the many pay in excess of their claims cost, what we can call "excess premiums," must roughly equal the claims generated by the few with high health care costs, what we can call "excess claims." Figure 1 below shows how these two amounts are roughly equal in a competitive insurance market.

When guarantee issue and other insurance regulations enter the picture, the rules of the game suddenly change. Uncertainty is eliminated from the insureds' side of the equation. If they are healthy, they do not need to pay premium dollars to the insurance company. Why should they? They can buy insurance when they need it!

As more people choose to go without insurance, the amount of excess premiums paid starts to shrink, but the excess claims do not. Figure 2 shows how heavy-

handed regulation of insurance pricing leads to insufficient premiums paid by the many to subsidize the excess claims of the few.

Can you guess what's next? Insurance premiums must be raised for those left in the pool to pay the excess claims. This leads still more people who cannot afford the higher premiums to drop their insurance, resulting in the situation shown by Figure 3. Note that people with excess claims have to keep their insurance no matter how expensive it gets.

Not Just a Story

So let's say you're 30, have a wife and two kids, and live in New Jersey. Your employer does not offer a group health plan, so you shop the market for private, individual health insurance. Get ready for sticker shock!

A boilerplate \$500 deductible, major medical plan (Plan "D") in New Jersey will set you back anywhere from \$2,433

"Since 1995, these 'reforms' have caused the number of people [in New Jersey] with private, individual health insurance to drop from 220,000 to 104,000."

to \$9,828 per month. That's \$29,196 to \$117,936 per year. And don't forget that if you're buying private, individual health insurance, you buy it with after-tax dollars. If you're in the 28 percent tax bracket, you have to earn over \$41,000 to buy a \$30,000 policy.

Is it any wonder so few people in New Jersey have private, individual health insurance? Could you afford to buy insurance at these prices?

What is remarkable is that liberal academics find ways to rationalize away these stupefying statistics. For example, in the July/August 1999 edition of *Health Affairs* (Vol. 18, No. 4), Katherine Swartz (Harvard School of

Public Health) and Deborah Garnick (Brandeis University) defended this program as the "most sweeping set of state reforms to promote broadly based competition in the market for individual health insurance." They had the audacity to say the plan "is a model for other states wishing to increase access to health insurance via market-oriented solutions that do not involve increased government financial obligation."

Pure nonsense, and bad advice for elected officials who want to do the right thing . . . or at least get reelected!

A Better Reform Plan

Health insurance, like all insurance, is founded upon risk. Both the insurer and the insured must be at risk. Coverage must be based upon risk factors. Rates must be based upon risk factors. When risk is not properly assessed and evenly shared, the end result ceases being insurance.

The best system for private, individual health insurance contains these elements:

- Carriers are permitted to underwrite and reject applicants who do not meet their underwriting guidelines.
- The state establishes a comprehensive health insurance plan so that people rejected in the private market can buy quality, heavily subsidized health insurance. More than half the states have such pools and they work well.
- Carriers are permitted to rate risks according to generally acceptable actuarial principles.
- Carriers are prohibited from singling out insured people who get sick for larger rate increases than people who remain healthy.
- Regulators are concerned primarily with the solvency of carriers, guaranteeing that carriers can meet their obligations.
- Politicians are chiefly concerned with fostering availability of products and competition among carriers.

One would have thought New Jersey policymakers would have awakened by now to the calamity they have caused in the state's private, individual health insurance market. Perhaps they will wake up when nobody can afford to buy private, individual health insurance coverage any longer.

Lee Tooman is vice president of government relations for Lawrenceville, Illinois-based Golden Rule Insurance Company.

Figure 1: In a competitive insurance market, excess premiums offset excess claims.

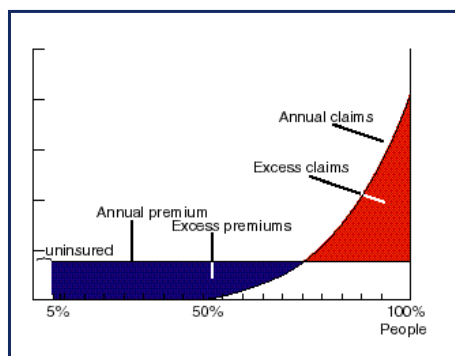


Figure 2: Regulation reduces the number of people who buy insurance, causing excess premiums to be less than excess claims.

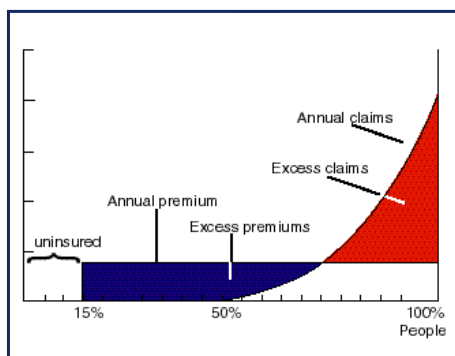
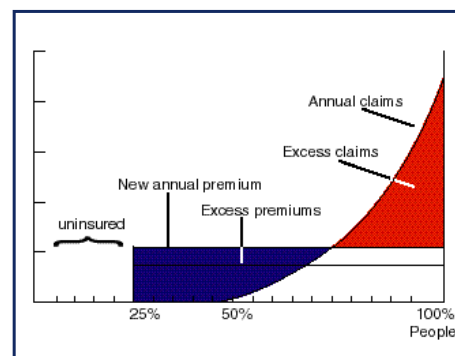


Figure 3: Insurance premiums rise to raise enough dollars from excess premiums to pay for excess claims.



How Drug Price Controls Hurt Consumers

BY JAMES W. MEEHAN JR.

Maine is at the forefront of efforts to regulate the price of prescription drugs. Last spring, the Pine Tree State passed the Prescription Drug Price Reduction Act, which directs state officials to negotiate lower prescription drug prices with pharmaceutical companies or, if unsuccessful in that effort, to impose price controls on pharmaceuticals.

In October 2000, a federal judge put the law on hold until a constitutional challenge raised by pharmaceutical companies is resolved.

Not to be deterred by the judge's injunction, Maine officials asked for and received from the Clinton administration a last-minute waiver that allows the state to expand eligibility for discounted prescription drugs under the Medicaid program. The waiver allows individuals with incomes up to 300 percent of the federal poverty level, who do not have prescription drug insurance and are not currently eligible for Medicaid, to buy prescription drugs at a 25 percent discount.

Because Medicaid requires the pharmaceutical companies to pay rebates, the waiver will extend the Medicaid price controls on prescription drugs to a much wider segment of the population. Further, Maine congressman Tom Allen recently introduced a bill in Congress to require pharmaceutical companies to sell prescription drugs at the average price the drugs sell for in six foreign countries.

The proponents of these regulatory measures argue they are necessary because prescription drug treatments can be expen-

"Targeted subsidies to low-income seniors and other low-income individuals would give them access to private prescription drug insurance plans, without skewing the economics of the prescription drug marketplace."

sive and many seniors, as well as other individuals living close to the poverty line, do not have insurance coverage for pharmaceutical drugs. Although the goal of providing seniors and low-income individuals with access to prescription drugs at an affordable cost is admirable, price controls are bad public policy that, in the long run, will increase the cost of prescription drugs to all citizens, including seniors and the poor.

The Essence of Price Controls

To understand why price controls are bad policy, it is important to carefully examine the cost structure of pharmaceutical companies and the pricing strategies they use to recover their costs.

The cost of discovering and developing a new prescription drug can run into the hundreds of millions of dollars. Despite these large expenditures on research and development, many new prescription drugs never make it into the marketplace, largely because of the enormously costly eight- to 10-year delays caused by the Food and Drug Administration's review process.

Investments in research and development must be made before the drug reaches the market, so these costs become fixed once they have been incurred. By contrast, the actual cost of manufacturing and marketing a successful prescription drug is quite small.

Pharmaceutical companies will continue to invest large sums in discovering and developing new prescription drugs only if they expect to recover their fixed cost, as well as their production and marketing

cost. This means the pharmaceutical companies must set prices significantly above the low cost of producing and marketing a unit of prescription drugs.

However, when the price is significantly higher than the cost of manufacturing a unit of prescription drugs, it becomes profitable for drug-makers to discriminate among customer groups, charging a lower price to some groups and a higher price to others. So long as the lower price generates additional sales and covers the cost of manufacturing a unit of drugs, it is profitable to sell to the new consumers at the lower price.

The fact that some consumer groups pay a lower price for the same prescription drug than others may seem unfair. However, the consumer groups that pay the higher price may actually benefit from the lower price charged to others. If the lower price to the favored group is greater than the cost of manufacturing the drug for them, the additional sales will generate extra revenues that can be used to cover some of the fixed research and development cost.

Most of the proposals to regulate prescription drug prices mandate that the pharmaceutical companies charge all consumers the same price. Unfortunately, these proposals are likely to harm all consumers, even the consumers they intend to help.

Negative Consequence of Artificial Pricing

If pharmaceutical companies are forced to charge a lower single price to all consumers, they may not be able to generate enough revenue to cover their fixed

research and development costs, including the costs of creating the vast majority of drugs that fail in the research and development stage.

In this case, the pharmaceutical companies may continue to produce existing drugs if they can cover their production cost, but they will cut back on their investments in research and development. What company can invest hundreds of millions of dollars to develop a new path-breaking

"[P]rice controls are bad public policy that, in the long run, will increase the cost of prescription drugs to all citizens, including seniors and the poor."

drug treatment when the government can force them to charge prices that do not recover all of their expected cost, including the cost of research and development for drugs that fail? Many of these lost drug treatments would have benefitted the elderly and the poor.

If prescription drug price regulations are not the answer, what should the government do? Targeted subsidies to low-income seniors and other low-income individuals would give them access to private prescription drug insurance plans, without skewing the economics of the prescription drug marketplace.

James W. Meehan Jr. is the Herbert E. Wadsworth Professor in the Department of Economics at Colby College in Waterville, Maine. Along with more than 500 economist colleagues, Meehan has signed an open letter organized by The Independent Institute opposing price controls in health care reforms.

For more information...



The Independent Institute's open letter is available on the group's Web site at <http://independent.org/tii/news/OpenLetterHealthCare0002.html>.

Canada No Model for Prescription Drug Reform

BY ROGER H. LEEMIS

The high cost of prescription drugs has caused many lawmakers to embrace Canada's nationalized health care system as a solution to America's woes.

During her successful campaign last year, Michigan Sen. Debbie Stabenow promoted bus trips to Canada for Medicare recipients seeking cheaper prescription drugs, little noting that Canadians often make the reverse trip across the Detroit River... not merely to save money, but to save their lives.

With the ongoing political maneuvering surrounding prescription drug benefits, now is a good time to focus again on why America must move away from, not

toward, the Canadian health care model.

To his credit, President George W. Bush has proposed a long-range Medicare reform plan that takes America in a more market-oriented direction. Unfortunately, however, his interim measure for this year's budget—creating a Medicare prescription drug benefit and throwing billions more in tax dollars at the problem—smacks of the command-and-control mentality that characterizes Canada's government-dominated system.

Why Are Drugs Cheaper?

Cross-border price differentials exist for a variety of reasons, including Canadian cost controls on prescription medicines.

But prescription cost is only a small part of the picture.

The Canadian system has been praised for its single-payer design and near-universal coverage. In essence, each province is the sole source of health care for its residents.

Provincial monopolies on health care financing are attractive in some ways. Canadian doctors don't face as much paperwork as they do under the U.S. system, patients are freed of all financial constraints, no one is uninsured (in theory, anyway), and costs are controlled.

This last feature is what enables American drug "tourists" to fill prescriptions for less than they can at home. However, the very factor that makes Canadian drug prices attractive—a centralized, government-controlled system—also creates intractable problems.

Single-Payer Problems

Because Canadian patients think medical care is "free," they demand lots of it. And because the government does not explicitly limit care and cannot charge for it, care must be rationed in various, often hidden, ways, resulting in long waiting lists.

What does it mean to be a patient in Canada? It's common knowledge many Canadians must wait a long time to see a specialist or receive lifesaving treatment. The Vancouver-based Fraser Institute tracks treatment delays; the 10th edition of its "Waiting Your Turn" survey reports that in 1999 a Canadian patient's average wait from referral by a general practitioner to treatment by a specialist had reached a record 14 weeks.

What about Canadians who come to the

SAVING LIVES continued from page 1

top 1,000 companies. According to the most recent survey, published in April 2000, the drug industry's median profit—the middle point between the most and least profitable of the 12 drug companies included—was 18 percent (profit as a percent of revenue) in 1999. Among drug companies, Amgen had the highest profit at 33 percent, with American Home Products the lowest, having lost 9 percent. Most companies reported profits in the range of 15 to 20 percent.

However, many companies that spend far less on research and development make more money than even the most profitable drug companies. Nabisco, for example, reported a 36 percent profit in 1999, according to *Fortune*. Coca-Cola—which produces a product that is competitively priced and very affordable—had higher profits than the drug industry median for most of the 1990s.

Gannett, publisher of *USA Today*, made 17 percent—right up there with the drug companies—and Tribune, a media conglomerate that includes the *Chicago Tribune*, the *Los Angeles Times*, and a number of broadcasting stations, made 46 percent profit, according to *Fortune*.

Software companies are important to this discussion because they, like the drug companies, are New Economy companies. They both make knowledge-based products and spend a lot of money up front researching and developing those products.

Pharmaceutical companies spent about \$24 billion developing and testing new

drugs in 2000—about 21 percent of their sales, more than any other industry and twice as much as the computer software industry. However, although software companies spent less than drug companies on R & D, Microsoft reported a 39 percent profit last year, while BMG Software reported 28 percent.

Charging High Prices?

While total spending on pharmaceuticals has been growing rapidly, averaging a 13.7 percent annual increase between 1995 and 1999, most of that spending is due to an increase in new products and volume of sales, not higher prices.

For example, while prescription drug sales grew by 18.8 percent in 1999, 14.6 percentage points of that growth was due to increased volume and new products, while only 4.2 percentage points of the increase was due to higher prices.

Drug companies aren't profitable because they charge so much; they're profitable because they make products that patients and their physicians want.

Patents Protecting Profits?

In many other industries—the soft drink industry, for example—copyrighted, patented, or trademarked products compete strongly, are heavily advertised and priced low, and still their manufacturers earn high profits. But nobody bemoans that fact . . . because they aren't prescription drugs.

The drug industry is highly competitive. No drug company has more than 7.2

percent of the U.S. market. For example, among the top 20 advertised prescription drugs in 1998, four were competing allergy medications.

True, the prescription drug market doesn't work exactly like a normal market, but that's primarily because physicians, who don't have to pay for the drugs, issue prescriptions for patients, who are usually insulated from the cost of drugs by their insurance.

“Critics claim advertising spending drives up the cost of drugs. In fact, those ads create more informed consumers and eventually may lower drug costs.”

The prescription drug industry could be even more competitive than it is today—which would have a price-lowering effect—if the industry faced fewer regulations, and if consumers demanded value for their drug dollars. Both are possible, but only if policy changes are made.

Advertising Effects?

Every Sunday newspaper is filled with advertising flyers for department stores, office products, computers, cars, food, and clothing. Yet no one complains they can't afford food because the grocery stores advertise. And does anyone really think they would be able to get a computer for less money if none of the computer manufacturers and retail outlets advertised?

Drug companies are increasingly advertising direct-to-consumer (DTC). In just 10 years, spending on DTC advertising by pharmaceutical companies has increased from \$55 million (1991) to an estimated \$1.8 billion in 2000. Most of that growth came after 1997, when the Food and Drug Administration (FDA) loosened its restrictions on DTC ads.

Critics claim advertising spending

drives up the cost of drugs. In fact, those ads create more informed consumers and eventually may lower drug costs.

Prior to the change in FDA guidelines, 41 percent of the physicians surveyed by IMS Health said they had observed an increase in patients' requests for brand-name drugs. After the change, 65 percent of the physicians surveyed noticed an increase in brand-name requests.

That is precisely the type of consumer behavior we want to encourage. Increasing consumer awareness, information, and demand is the first step in the market process that eventually can lead to price competition among drug manufacturers.

Price Controls as a Solution?

Many critics of the drug industry contend that the quickest, most effective way to ensure Americans have access to affordable prescription drugs is to impose price controls, as many other industrialized nations, including Canada, have done.

While it is true that residents of countries with prescription drug price controls pay less for some drugs, they pay more for others . . . if they can get them at all. For example, an April 1999 comparison of drug costs in several countries by Prof. Patricia M. Danzon of the University of Pennsylvania's Wharton School of Business found that “Canadian prices are between 13 percent lower and 3 percent higher than the U.S., depending on the price index used.” Moreover, generic drugs, which make up 45 percent of the American prescription drug market, tend to cost more in Canada than in the U.S.

However, the biggest problem may be access. According to Dr. William McArthur, a Canadian physician and formerly the chief coroner in Vancouver, between 1994 and 1998 the Canadian government considered some 400 new drugs but “ruled that only 24—or 6 percent—were substantial improvements over their predecessors.”

In addition, each of the 10 Canadian provinces has a review committee that must approve any new drug for the province's formulary. “Of 99 new drugs approved by the federal government in 1998 and 1999, only 25 were listed on the Ontario formulary,” according to Dr. McArthur.

Since Canadians must pay out-of-pocket for unapproved drugs, demand is low, and pharmacies have little incentive to stock them. As a result, many Canadians travel to the U.S., paying out-of-pocket to get the drugs they need.

Conclusion

While it is true that many prescription drugs are expensive, those drugs and the millions of dollars in research that created them benefit millions of Americans every day. If we want that research to continue, we must realize that drug company profits aren't a problem—they're the solution.

Merrill Matthews Jr., Ph.D., is a visiting scholar with the Institute for Policy Innovation, policy director for the American Conservative Network, and assistant editor of Health Care News.



United States for care? A few may be seeking experimental treatment, but most come to get timely care. Precise numbers are difficult to come by, but unpublished survey data collected by the Fraser Institute indicate more than 2 percent of Ontario patients have obtained treatment outside of Canada. For cancer patients, more than 5 percent of those in Ontario needing radiation therapy have left Canada to be treated.

Treatment delays for cancer patients have gotten so bad that, as *The Detroit News* has reported, Cancer Center Ontario (a government agency) entered into contracts to “export” cancer patients to Detroit's Barbara Ann Karmanos Cancer Institute, as well as to medical centers in Cleveland and Buffalo.

While those contracts covered only radiation treatments for breast cancer and

prostate cancer patients, they remain a stunning admission that Ontario's health system cannot provide treatment within a reasonable time. In 1999, half of all Ontario patients diagnosed with cancer waited eight weeks or more to begin radiation treatment.

Canadian Drugs No Model

American drug tourists and border-crossing Canadian patients alike are responding to the economic realities of Canada's health-care system. But Canadian drug bargains for Americans near the border—an accident of geography—do not mean the United States should adopt greater government control over the price of prescription drugs.

After all, few would argue that bar-

gains at the duty-free store are a reason to adopt Canada's tax system, complete with steep, value-added tax rates.

Waiting lists and delays in treatment are the inevitable and systemic consequences of Canada's government monopoly on health care.

Policymakers in Washington may finally be realizing this. But any time they're tempted to look across the border for answers, they would do well to notice those Canadians coming over to our side for lifesaving treatment.

Roger H. Leemis practices health law in Southfield, Michigan and is an adjunct scholar with the Mackinac Center for Public Policy, a research and educational institute headquartered in Midland, Michigan.

The TRIUMPH of LIBERTY

The Heartland Institute's 17th Anniversary Benefit Dinner
October 26, 2001 ~ Chicago



Linda Chavez:

**"Still Fighting for
the American Dream"**

Linda Chavez is president of the Center for Equal Opportunity, a non-profit public policy research organization in Washington, DC. She also writes a weekly syndicated column that appears in newspapers across the country (including the *Chicago Sun-Times*), and is a political analyst for FOX News Channel.

Chavez is the author of *Out of the Barrio: Toward a New Politics of Hispanic Assimilation* (Basic Books, 1991), which the *Denver Post* said "should explode the stereotypes about Hispanics that have clouded the minds of patronizing liberals and xenophobic conservatives alike." *The Washington Post* describes Chavez as one of "a new generation of intellectuals [seeking] to question the orthodoxies of the civil rights establishment." Chavez is well known for her syndicated newspaper column and writings for other publications, including the *Wall Street Journal*, *The New Republic*, the *Washington Post*, and *Reader's Digest*.



Mark Skousen:

**"The Vindication
of Adam Smith"**

Mark Skousen is an investment advisor, author, and dynamic world-renowned speaker. A self-described "almost idealistic" proponent of liberty and political freedom with a Ph.D. in economics, Skousen is actively involved in some of the most prestigious free-market and liberty think tanks in the world.

Skousen is the author of many books, including *The Making of Modern Economics* (M.E. Sharpe Publishers, 2001), *Economic Logic* (Skousen Publishing, Inc., 2000), *Economics of a Pure Gold Standard* (Foundation for Economic Education, 1997), and *Complete Guide to Financial Privacy* (Simon & Schuster, 1983).

Skousen has built a reputation for accurately identifying not only economic and political trends, but also the right investments for the times. *Mark Skousen's Forecasts & Strategies* has grown to become one of the largest financial newsletters in the country.

TICKETS

MEMBERS: \$95 before August 15;
\$110 after; \$125 at the door

NONMEMBERS: \$110 before August 15;
\$125 after; \$150 at the door

TABLES

PLATINUM \$7,500
GOLD \$5,000
SILVER \$2,500
RESERVED \$1,500

DISCOUNTS

FIRST-TIME ATTENDEES, take \$25 off your ticket price (does not apply to guests)

Buy FIVE OR MORE TICKETS and take 15 percent off the total price. All tickets must be purchased at the same time to qualify for group discount.

FOUR EASY WAYS TO BUY TICKETS!

PHONE Call us at 312/377-4000 and ask to reserve tickets for the 17th Anniversary Benefit. Have your Visa, Master Card, or American Express card ready.

FAX Complete the form on page 17 and fax it to us at 312/377-5000.

MAIL Complete the form on page 17 and mail it with your check, money order, or credit card information to The Heartland Institute, 19 South LaSalle Street #903, Chicago, IL 60603.

ONLINE Visit Heartland's Web Site at www.heartland.org and click on the "Heartland Store" to register online.

**REGISTER NOW AND
SAVE \$15 PER TICKET!**

How Much Should We Spend on Health Care?

BY GREG SCANDLEN

Here we go again. Another round of health insurance rate hikes. This time, premiums are going up 10 to 20 percent, and in some states even more. Health care costs generally are rising at two to three times the rate of inflation.

According to some critics, the culprit this time is prescription drugs—not the price of drugs, but the newest round of expensive medications that never existed before. The drug manufacturers, it is charged, are creating demand where none existed by advertising directly to consumers, often on television.

Such advertising probably does create demand. If fewer people know about the drugs, fewer will ask their doctors about them and thus fewer drugs will be prescribed. Is that diminution of demand a good thing? Not if you are the one who has allergies or arthritis or impotence.

Health Care Costs vs. Other Costs

But advertising isn't the problem. We advertise potato chips and soda pop. More people buy these products because they are advertised, and spending on snack food increases. But no one gets upset.

It's true the United States spends a lot of money on health care—\$1,023 billion in 1998, according to the Bureau of Economic Analysis. But, as is shown in the "Selected Personal Consumption" table, we spend a lot of money on a lot of things. Who is to say what the right amount is for any of those expenditures? If we spent less on health care, would we spend more on food? Or recreation? Or transportation?

The health policy community has been in a state of periodic panic over health care spending since the early 1970s. Observers

then complained about "spiraling health care costs," which equaled 7 percent of the gross national product in 1970. President Nixon imposed federal wage and price controls in 1971, primarily because of growing health care costs. But by 1975 health care was absorbing 8.3 percent of the GNP, and the crisis worsened. Today, health care is nearly 15 percent of the economy . . . and we have somehow managed to survive.

While policymakers seem to be persistently vexed over health care spending, most Americans think we spend too little on health care. Responses to annual surveys taken from 1973 to 1998 have been amazingly consistent: about two-thirds of Americans think we spend too little, and less than 10 percent think we spend too much. (See accompanying figure, "How Americans Feel About Health Care Spending.")

Who Pays?

Why do the pundits and the people have such divergent views? Because few Americans have any idea what health care costs or how much is being spent on their behalf. Someone else is paying the bill. That someone else may be the government, an employer, or an insurance company. For at least 40 years, the portion of

health care services paid directly by patients has dropped every year, while the portion paid by third parties has increased.

Because consumers are free of any concern about costs, payers are forced to step into the middle of the medical transaction and exercise their own judgment about what is worth paying for. But their judgments may be at odds with the values of patients and doctors. For instance, a payer may decide new mothers can go home within 24 hours of giving birth, but some mothers may disagree and resent the pressure to leave the hospital so quickly.

Lacking market clout, ordinary voters turn to politicians to correct what they view as unfair constraints on health care spending. And as politicians succeed in disarming the payers, the war against increasing costs is bound to be lost.

One Size Doesn't Fit All

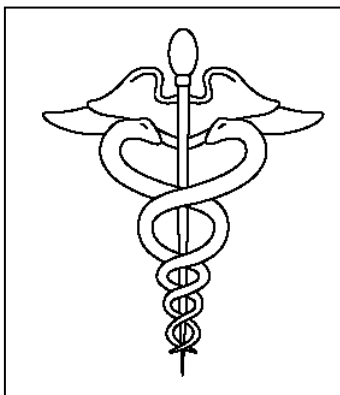
Legal remedies are clumsy. A new law, like a mandate to cover certain treatments or providers, must be applied to every-

one, including to people who don't care or are opposed to the provision. A requirement that an insurance plan cover abortions and contraceptive devices must apply to all insurance plans, even those purchased by religious objectors to those procedures. Some people have suggested using "conscience clauses" to exempt churches from such requirements. But people who don't work in a church setting may have equally strong convictions about the morality of the provision.

This is the kind of nuance laws can

never address, but markets can address very well. Market systems enable all individual consumers to purchase exactly those goods and services they value and to shun those they don't. Consumers make daily decisions about how best to spend their resources to get the most value from their funds. We get not only choco-

"Under today's system of health care financing, we cannot know what consumers prefer because they must accept whatever the insurance company, the government, or their employer will pay for."



late and vanilla, but 29 or more other flavors as well. Only 2 or 3 percent of the population may like pistachio ice cream, but the market serves it to them, just as it does the more popular flavors.

Needed: Consumer Choice

The question is not whether one trillion dollars is too much or too little to spend, or whether we would be better off spending some of that money on something else. Consumers never decided to spend a trillion dollars on health care, at least not rationally. That money did not have to compete with the rest of the economy for the hearts and minds of the American people. We don't know whether people feel they are getting their money's worth, because they never knew how much money is being spent.

If consumers were in control of their own resources, they might decide to spend far more or much less on health care. It is quite likely they would change their pattern of consumption. Some might spend more money on chiropractors or home health or nurse practitioners, and less on doctors and hospitals.

They might prefer a nurse midwife over an obstetrician, and they might prefer home birth over a hospital stay, then spend the savings on a new crib for the baby. But under today's system of health care financing, we cannot know what consumers prefer because they must accept whatever the insurance company, the government, or their employer will pay for.

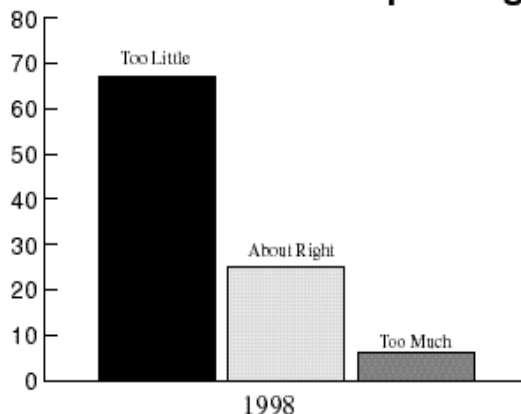
Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis and assistant editor of Health Care News.

Selected Personal Consumption Expenditures in the U.S., 1998 (billions)

Food and tobacco	\$907.4
Clothing, accessories, jewelry	367.9
Housing	855.9
Household operation	646.5
Medical care	1,032.3
Personal business	528.6
Transportation	647.4
Recreation	494.7

Source: Bureau of Economic Affairs, U.S. Department of Commerce, from *World Almanac*, 2001, p. 132.

How Americans Feel About Health Care Spending



Source: Bob Blendon, *Health Affairs*, March/April 2001, p. 36.

Doing the "Do Something" Shuffle

Bureaucrats and policy wonks addressing a "transformative change" seminar demonstrate little support for market-driven health care approaches

BY SAM MACDONALD

Hope glimmered for America's bloated medical economy on June 4, when Thomas Scully made his public debut as head of the Health Care Financing Administration, the federal agency that provides health insurance to over 74 million people through Medicare, Medicaid, and the State Children's Health Insurance program.

Scully addressed a symposium on "Transformative Change: Market-Driven Health Care," and the spark of hope he ignited was that under the wonkese there might lurk actual plans for common-sense pricing and deregulation. "My real goal at HCFA is to change things . . . to make a radical change," promised the enthusiastic Scully.

But hope's spark quickly turned into the usual Washington ash. Instead of real systemic change, the assembled bureaucrats seemed poised to deliver—at best—a few name changes to existing agencies and programs. Judging from the symposium, America can expect to go down the capital's well-worn path to nowhere, paved with "bipartisan compromise." Indeed, the

event drew heavily on the political habit of invoking change as a way of sidestepping it entirely.

The Galen Institute and National Center for Policy Analysis—both market-oriented think tanks—cosponsored the event with the American Medical Association. It went down on prime real estate, at the U.S. Chamber of Commerce headquarters, just across Lafayette Square from the White House. But not even the heavyweights assembled could change the fact that the American health care system will get worse before it gets any better.

The Internet Will Save Us

The event started out well enough, with a steady stream of business interests and policy wonks cheering the notion of tax credits that would liberate people from the current system of employer-mandated, government-restricted care.

This is a pretty straightforward line: Let people pick their own damn health insurance. Like so many other theories that promise to free us from tyranny, this one rests its hopes on the Internet. Technology gives workers better access to information; information allows them to make the best health care choices for their own families. In the future, we'll all use "defined contributions" from employers and generous pre-tax income rebates to buy what we want from the company we like.

Want better coverage? Pony up the cash. Rather roll the dice? Stick with a more basic plan and spend the dough on something sexy for the wife (or the husband). Either way, by letting people know how much they actually spend on health care and by giving more coverage to people who are willing to pay for it, the new system would address our current woes by implementing "market" solutions.

Two immediate problems arise. First, forcing people to buy health care with money you've "given" them in the form of tax rebates doesn't seem like much of a market solution. Second, managed-market schemes have proven miserable failures in the past (anyone remember California's phony "market" solution to high energy prices?).

Not to worry. Odds are slim to none that any plan Congress hashes out over the next few months will resemble a market in any real sense. That became clear over lunch, when Scully delivered his first public presentation to the 120-or-so people assembled. He seemed like a likable guy: young, ambitious, and affable. He even managed to break D.C. convention and show his down-home commitment to results by dropping a few harmless obscenities into his speech. (I counted one hell and two damns.)

To his credit, Scully did focus on some marginally market-based approaches, such as medical savings accounts that consumers can roll over year-to-year. He also boldly admitted that the bureaucratic culture at HCFA, infamous for red tape and non-responsiveness, needed to change.

Unfortunately, even these half-steps took a back seat to what Scully said was one of the top priorities of Health and Human Services Secretary Tommy Thompson: "So where are we going to start? The first thing is, people think this is a joke but it's not, but we are going to change the name. Guaranteed. You can bet your life on it."

Scully said Thompson had already received thousands of suggestions, and he all but promised to deliver the agency's new moniker by July 1. How can years of bureaucratic ineptitude stand a chance against such an innovative approach?

Do Something!

That was Scully's first step in a well-known Washington dance, the one bureaucrats do whenever they hear reformers striking up the band. Its purpose is to show that they, too, are willing participants at the ball . . . without actually making progress across the dance floor.

Scully quickly took another such step. He threatened to "do something" about a variety of issues. "There clearly needs to be something done in the prescription drug area, in cost and on access." He promised the agency would "gradually and rationally redesign the way we deal with prescription drugs without blowing up the system."

Participants at a panel after lunch soon showed they too had fleet feet, confirming the administration's devotion to decidedly non-market-based schemes. Sally Canfield, counselor to the HHS secretary, demonstrated the "political" two-step. She said of prescription drug coverage: "We can't let that go. It is so important. It's so fundamental." Then she performed the "streamlining" back-step. Canfield explained HHS would be streamlined—a point that might have been more convincing had it not come after she finished discussing plans to double the budget at the National Institutes of Health by 2003.

Dean Rosen, staff director for the Senate Health, Education, Labor and Pensions

"New names. Expanded coverage for prescriptions. Bipartisan legislation that appeals to both Democrats and Republicans. Why hadn't anyone thought of this before?"

Committee, showed off the down-the-middle minuet. He promised the newly reorganized Senate would get in on the act by creating bills that will satisfy both sides of the aisle: "There is no all-or-nothing solution."

New names. Expanded coverage for prescriptions. Bipartisan legislation that appeals to both Democrats and Republicans. Why hadn't anyone thought of this before? It's all "transformative change," as the name of the conference suggested, but in reality it's not going to be all that "market driven" at all. In Washington, the band plays on.

Sam MacDonald (smacdonald@reason.com) is Washington editor for Reason magazine. Reprinted, with permission, from Reason Online. Copyright 2001 by Reason Foundation, 3415 South Sepulveda Boulevard #400, Los Angeles, CA, 90034; <http://www.reason.com>.

For more information...

WWW To view a Webcast of the "Transformative Change" conference, visit the U.S. Chamber of Commerce Web site at http://www.uschamber.com/chambercast/_healthbriefing.

HEALTH CARE NEWS

The monthly newspaper for market-based reform of the nation's health care system

Health Care News focuses on the most promising market-based solutions to health care problems, including:

- Medical savings accounts
- Defined contribution insurance
- Repeal of mandates
- Tax fairness
- Competition and choice

Free copies of Health Care News are sent each month to every state and national elected official in the U.S. and thousands of doctors, insurance brokers, policy analysts, and pharmacists who share an interest in market-based reform. Please complete and return one of the forms on page 19 if you wish to continue receiving this publication, and urge your friends and colleagues to fill out and return forms too.

Health Care News is a publication of The Heartland Institute, a nonprofit research organization based in Chicago, Illinois. For more information, visit our Web site at www.heartland.org, call us at 312/377-4000, or contact us by mail at 19 South LaSalle, Suite 903, Chicago, Illinois 60603.



THE GALEN REPORT

A monthly review of health policy matters

The June 4 conference on "Transformative Change through Market-Driven Health Care" was a major success with full attendance throughout the day. Speakers were well prepared, and the audience was filled with experts who are health care leaders in their own right.

The conference succeeded on several levels: First, a diverse and knowledgeable series of speakers conveyed valuable information about the changes taking place in the real world, the policy initiatives that will facilitate further change, and what the new world of a true free market in the health sector would look like.

Equally important, people who are working hard to further market-based reform had an opportunity to see how this community has grown, with experts from as far away as Washington State coming to learn and share their expertise. Finally, it was great to see the U.S. Chamber and the AMA, which have been in high-profile battles over the patients' bill of rights, come together on the critical issue of new incentives for health insurance based upon a competitive free market.

The conference also made major headlines, somewhat to the dismay of speaker Tom Scully, the new HCFA administrator. The *Washington Post* led with a report on Scully's luncheon speech at the conference, saying HCFA plans to issue "detailed ratings of the quality of care" given to Medicare beneficiaries. The story seemed quite a stretch to those of us who heard the speech, and it certainly angered the medical community.

The following day, HCFA issued a statement saying the agency has no plans to "create a scorecard of ratings." Rather, the statement said HCFA plans only to "improve the state and private information it collects on nursing homes, dialysis centers and other health care providers."

While the headlines of the conference concerned

Medicare, the substance of the conference focused on ways to get more power and control into the hands of individuals to make their own health care arrangements. Scully said he felt refundable tax credits for the uninsured are essential and regretted they were not included in the President's tax reduction bill. He said they are a priority both for him and for Health and Human Services Secretary Tommy Thompson.

Sally Canfield of HHS and Dean Rosen of the Senate Public Health Subcommittee were cautiously optimistic in an afternoon session that progress on refundable tax credits would be made on Capitol Hill.

AIDS Drugs Not Enough

While modern medicines can perform near-miracles, even the newest and best drugs alone aren't enough for a crisis as serious and widespread as the tragedy of AIDS in Africa. Health education and a better health care infrastructure are needed in Africa, and public poli-

cies that protect intellectual property and lift price controls are needed in developed countries. Notes an editorial in the April 20 edition of *The Wall Street Journal Europe*, "The hard truth is that the complex, expensive antiretroviral regime is simply not the answer to Africa's AIDS pandemic."

The debate about prescription drug availability for AIDS victims in sub-Saharan Africa reached a crescendo after pharmaceutical companies settled a lawsuit over patent infringement by the South African government. The problem is much larger than the need for less-expensive drugs.

The crisis is poised to affect the domestic policy debate in the United States as well: United Nations Secretary-General Kofi Annan has called on "rich countries" to contribute \$7 to \$10 billion to a "war chest" for a huge global fund to battle AIDS in developing nations. He is challenging the Bush administration to contribute funds that would otherwise go to tax cuts.

World Health Policy Experts Meet

Meanwhile, experts in health care and pension reform traveled from London, Brussels, Stockholm, Germany, Paris, and elsewhere to speak in Washington on April 26 at a conference sponsored by The Heritage Foundation and the Centre for the New Europe. This refreshing assembly of free-market thinkers from Europe and the U.K. explained the chilling details of their coming crises in health care and pension programs.

Dr. David Green of the Institute for the Study of Civil Society in London said the goal of the National Health Service in the U.K. is for health care to be "free at the time of service, have equal service for all, high quality, guaranteed access, and comprehensive benefits. In reality, it is the determination to keep it free at the time of service that has kept it from meeting any of the other goals."

Paul Belien of the Centre for the New Europe (CNE) in Brussels agreed. "Gradually, health care in Europe is becoming a horror story. Access to medical care, particularly drug treatments, is driven by whether or not your disease is the political favorite of the moment." He said there are a few bright spots: Germany, the Netherlands, and Switzerland, he noted, allow citizens to cash-out their tax-supported benefits to make their own choices for health care.

Heritage and the CNE plan to publish the proceedings.

Responsible Tax Credits

And speaking of coming publications, Mark Pauly of the Wharton School and John Hoff, health care attorney and trustee of the Galen Institute, presented their new plan for "Responsible Tax Credits for Health Insurance" at an AEI conference on April 20. AEI will publish the plan this summer, but already it is receiving kudos for getting both the vision and the details right.

AEI also hosted a briefing in April for members of the German parliament, in Washington to explore the U.S. health care system. The U.S. health policy analysts who addressed the group did their best to dispel myths about how barbaric we are in the U.S., but their perceptions are very entrenched. When they hear 42 million uninsured, they think 42 million people bleeding in the streets—a perception that leads them to disregard suggestions we might have about the value of market forces.

David Green points out that discussions with European health officials would be made easier if the

U.S. were to adopt tax credits for the uninsured. Doing so would show the Europeans we are using the free market to help the uninsured.

Mark Your Calendars

July 31, 2001 Making a Federal Case out of Health Care: Five Years of HIPAA, A Cato Institute Conference. Speakers will include Richard Epstein, Mark Pauly, Fred Cate, Mark Hal, John Hoff, Greg Scandlen, and *Health Care News* Managing Editor Conrad F. Meier. To register, call 202/218-4633.

The Galen Report is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA, 22320. Grace-Marie Arnett is president of The Galen Institute; this report is compiled by editor Liz Turner. Turner can be contacted at 703/299-9550, or visit Galen's Web site at <http://www.galen.org>.



**PolicyBot™ gives you free,
instant access to the
complete texts of over
7,000 studies, reports,
articles, and other
documents on
today's hottest
public policy issues.**

**PolicyBot™
The information you need,
when you need it.**

@

www.heartland.org



CarCare and Medicare: A Fable for Today

BY MICHAEL ARNOLD GUECK, M.D.
AND ROBERT J. CIHAK, M.D.

“Cars are just too expensive for seniors,” thundered the politician as he unveiled his new plan. Not daring to anger the AARP lobbyists nearby, his colleagues bobbed their heads in agreement. When the vote came up, the bill passed with nary a nay vote.

A new payroll tax was imposed on anyone who did not work for the government. Acting as agents of the Department of Treasury, employers collected the tax from their employees’ paychecks. The feds used the money to buy the cars, then paid the auto dealers about 20 percent of the market prices.

Soon, every senior had a car through the government program cleverly called “CarCare.”

And then came the unintended consequences.

The showrooms of some dealers were cleaned out as seniors clamored for luxury cars at the government’s bargain-basement price. Some dealers went out of business, facing bankruptcy because they had to sell so many pricey cars at a loss. Other dealers stayed afloat, at least for a while, by raising the prices on all their cars.

When a shortage of cars developed, seniors tried to buy cars outside the program, with their own money. But the government said that was illegal, and threw the dealers in jail.

Not So Far-Fetched

Does the CarCare story strike you as far-fetched? Just substitute Medicare for CarCare, and doctors for dealers.

When Medicare was launched in 1967, many Americans supported it. The federal government had, in essence, obligated

itself to pay for most medical spending for most Americans over age 65. Who could refuse?

But the country responded to Medicare in the same way as our mythical senior citizens did to CarCare. Many Medicare

“According to a survey conducted by the Association of American Physicians and Surgeons, . . . roughly one-fourth of the nation’s doctors are refusing to accept new Medicare patients.”

patients sought out highly trained specialists, better hospitals, and more expensive treatments. Demand for health care escalated . . . because patients used the system as it was designed to be used.

The grandmother of a friend of ours was a very frugal woman who rarely saw the doctor—until Medicare was established. Then, because Medicare would pay for one doctor visit every month, she saw her doctor every month.

Soon Medicare spending projections were off by 1,000 percent. The planners had not adequately planned for the unintended consequences. The unexpectedly dramatic increase in demand for more and higher quality services put serious inflationary pressure on medical prices. If the CarCare program had been launched in

1967 and followed Medicare’s lead, the average automobile would now have a list price of roughly \$100,000.

When the politicians were called on to come up with more money for Medicare, they cried foul and sought a scapegoat to blame for their budgeting folly. As there aren’t as many physician-voters as there are Medicare-voters or even government-bureaucrat-voters, the politicians turned up the heat on doctors.

Fraud Net Catches the Innocent

In 1996, Congress made it a crime to make a mistake, criminalizing clerical billing errors made by Medicare providers. As a result, many capable and honest doctors have been victimized by government prosecutors. Yes, criminals have been caught, but at least as many honest doctors have been driven from practice, forced into early retirement, financially ruined, or even jailed because of “overzealous” prosecution.

Yet, Medicare *invites* fraud. Unlike credit card statements or other bills, Medicare billings are often never even seen by the patient. On the rare occasion a patient receives a hospital billing copy, it’s so riddled with uninterpretable codes and acronyms and abbreviations the patient needs another consultation with the doctor just to understand it all. And in the end, since the government pays most of the charges anyway, what’s the point of trying to figure it out?

The effort to ferret out Medicare fraud and abuse has had unintended consequences. According to a survey conducted by the Association of American Physicians and Surgeons, published in February 2000, roughly one-fourth of the nation’s doctors are refusing to accept new Medicare patients. The top reason survey respondents gave was “hassles or threats” from the government. The amount of the fees paid to physicians providing care to Medicare patients was a distant fourth.

If the real aim of the government’s anti-fraud effort is not to persecute doctors, but to cut waste, and thereby costs, in the Medicare program, there are better ways. If patients were to pay their doctors directly, fraud would be significantly curtailed. The Medicare check and a comprehensible explanation of services should be sent directly to the patients, who in turn should pay their providers.

Yet government is so intent on controlling the Medicare program they make it nearly impossible for doctors to provide additional care to patients willing to pay for it, or even free medical care to those who cannot. Doctors offering those services face criminal prosecution and jail time.

In 1995, the Association of American Physicians and Surgeons marked the first “Medicare Patient Freedom Day” by treating patients for \$1 cash, while refusing to file claims for reimbursement from taxpayers. The government responded by saying it was illegal not to file a claim for payment. AAPS President Jane Orient, M.D., declared, “Doctors should refuse to be willing participants in this game of regulatory Russian roulette.”

It would seem fair to call the Medicare system “dysfunctional” when it allocates one billion dollars to lawyers and inves-

tigators to search out and destroy fraud, while paying dimes on the dollar to the providers of medical care.

Rethinking the Entitlement

When asked why he robbed banks, Willie Sutton answered, “because that’s where the money is.” While no one would accuse Medicare patients of robbery—they’re merely behaving as the program was designed to have them behave—the fact remains Medicare is where the money is. As long as we think of Medicare as an unlimited entitlement, the question may not be *how* to fix Medicare, but can it be fixed at all?

We hope legislators with a flair for fairness will reassert themselves and come to understand it is unfair to ask lower-paid,

“It would seem fair to call the Medicare system ‘dysfunctional’ when it allocates one billion dollars to lawyers and investigators to search out and destroy fraud, while paying dimes on the dollar to the providers of medical care.”

young workers supporting a growing family (and perhaps even their own parents) to subsidize the medical care of those senior citizens who can afford to pay their own way. Baby boomers are fast approaching Medicare age; it may well be time to reinvent Medicare to fit the demographics of the twenty-first century.

Doctors are Healers, not Bureaucrats

Most observers would agree that Medicare patients should have greater freedom to choose their doctor. But the program today discourages many fine physicians who would rather be taking care of patients than pushing paper. Attempting compliance with the enormously complicated and often poorly defined Medicare regulations is time-consuming at best . . . and dangerous at worst. The penalties for incorrect paperwork—fraud, the government calls it—are stiff.

According to the AAPS survey referred to earlier, doctors spend an average of 500 hours a year—more than two months of eight-hour workdays—dealing with the Medicare maze. Who could disagree that time would be better spent treating Medicare patients?

Michael Arnold Glueck, M.D., of Newport Beach, California, writes extensively on medical, legal, disability, and mental health reform issues. Robert J. Cihak, M.D., of Aberdeen, Washington, is currently president of the Association of American Physicians and Surgeons.

MANAGED continued from page 1**What Is Managed Care?**

Together, we can learn a lot and, I hope, appreciate the role of managed care in our country. I also expect you will come to believe, as I already do, that managed care has been good for us, and its future role in our nation's health care system is even brighter.

The best place to start is with a definition of managed care: any centrally

"The 1940s saw two 'defining moments' in U.S. health care. The first was the creation of employer-based insurance. . . . The second . . . came at the end of World War II, when the health care system in the U.S. was dramatically expanded."

financed and controlled system of the delivery of health care services.

Control may be loose or tight, depending on the insurance contract held by an individual. In preferred provider organizations (PPOs), for example, the patient may have available a broad selection of physicians—even specialists he or she can choose as needed or desired.

In a health maintenance organization (HMO), the patient probably will be required to get a primary care physician's approval before seeing a specialist, and even then, the choice of specialist may be very limited. In some cases, no choice of specialist may be available at all under the HMO coverage.

Within the spectrum of managed care organizations are:

- independent physician associations (IPAs)
- preferred provider organizations (PPOs)
- point of service plans (POSs)
- health maintenance organizations—staff model, where most physicians are employed by the insuring organization
- health maintenance organizations—group model, where most physicians are not employed by the insuring organization, but are probably members of a physician group. They work on contract with the insuring organization.

Defining Moments

While there are many variations on managed care, they share a common history.

The 1940s saw two "defining moments" in U.S. health care. The first was the creation of employer-based insurance. That occurred because the federal government controlled wages during World War II, but did not control employee benefits. As a result, employers used benefits to attract and reward employees, because wages were controlled.

The second "defining moment" came at the end of World War II, when the health care system in the U.S. was dramatically expanded. Government money was made available to build hospitals, educate more doctors and nurses, expand research efforts, etc. As a result of those funding decisions, the U.S. developed the most expensive health care system in the world.

Employer-provided health insurance—the first "defining moment"—protected the vast majority of Americans from these increasing costs. For the most part, individual Americans were pleased to see health care grow more complex and expensive: We were "off the hook" for the cost, and we liked the idea of having a health care system that could treat, perhaps even cure, everything. We could see almost any physician, anytime. We had freedom of choice and no concern for cost.

Few of us even paid attention to our own self-destructive lifestyles. The health care system would take care of everything, at little cost to us.

Bursting Our Bubble

Eventually, we learned the hard way that all good things must come to an end. The cost of health care in the U.S. became overwhelming, crowding out other items in our personal, corporate, and government budgets. Federal and state treasuries and many employers reeled under the increasing burden of Medicare, Medicaid, and other health-related programs.

In response to these pressures, the delivery of health care services began to change rapidly. Managed care became a household word in the 1970s, touted as the key to controlling the growth of health care spending.

"Managed care slowed significantly the inexorable increase in the nation's health care spending."

Good examples of cost-control were everywhere. The Kaiser-Permanente organization in California was successfully caring for patients within a single organization; they employed almost all of the physicians and other personnel, and even owned the hospitals. In the Pacific Northwest, Group Health of Puget Sound was similar. Patients were satisfied with the care, and costs were lower than would have been expected for the geographic area. These became examples of how health care services could be delivered at lower cost.

A silver lining, in the form of a new method for providing patient care, had been found in the health care cost cloud. Instead of total patient choice and uncontrolled use of specialists, these "successful HMOs" provided for a single patient contact physician who decided when to utilize specialists. The HMOs created patient care protocols (procedures) that emphasized more use of primary care physicians and less dependence on specialists, expensive pro-

cedures, and high-tech equipment. Those measures saved money; research concluded patients were satisfied and care of appropriate quality was being delivered.

The federal government encouraged widespread deployment of the managed care model. Hospitals merged and large health care networks were created. Many of these networks established their own insurance companies, while others participated in joint ventures combining insurance companies, hospitals, physicians, and other parties. Soon, the majority of insured Americans were receiving their care from a managed care organization.

Managed care options were made available—sometimes as a choice, at other times as the only option—to Medicaid and Medicare beneficiaries. Managed care became the norm. It slowed significantly the inexorable increase in the nation's health care spending. Governments at all levels breathed more easily. The cost monster appeared under control.

On the Downside

The ascendancy of managed care was not without a downside. Stories were told of care delivered impersonally . . . or not at all. Complicated approval processes for specialists were derided, and those who opposed managed care decried the lack of physician choice. State legislatures began debating such health care specifics as the appropriate length of a hospital stay for mothers who had just delivered babies; the federal government started considering a "Patient's Bill of Rights." These were—and are still—exciting times.

The next two issues of *Health Care News* will consider the problems of managed care and explain why—and how—managed care should be kept alive and well.

Stuart A. Wesbury Jr., Ph.D. is professor emeritus in the School of Health Administration and Policy at Arizona State University's College of Business. With Joseph L. Bast and Richard C. Rue, Wesbury is the coauthor of Why We Spend Too Much On Health Care (1993). He can be reached by email at stu.wesbury@asu.edu.

THE TRIUMPH OF LIBERTY

Attend Heartland's 17th Anniversary Benefit Dinner - October 26, 2001

SINGLE TICKETS - MEMBERS:

- ☐ \$95 before August 15
☐ \$110 after

SINGLE TICKETS - NONMEMBERS:

- ☐ \$110 before August 15
☐ \$125 after

RESERVED TABLES

- ☐ PLATINUM \$7,500
☐ GOLD \$5,000
☐ SILVER \$2,500
☐ RESERVED \$1,500

Check the appropriate box and write in the number of tickets you are ordering.

DISCOUNTS

FIRST-TIME ATTENDEES, take \$25 off your ticket price (does not apply to guests)

Buy **FIVE OR MORE TICKETS** and take 15 percent off the total price. All tickets must be purchased at the same time to qualify for group discount.

Discounts cannot be combined and do not apply to table reservations.

☐ My check in the amount of \$_____ is enclosed.

☐ First-time attendee ☐ Five or more tickets

☐ Charge \$_____ to my ☐ Visa ☐ MC ☐ Am Ex

Account Number _____

Expiration Date _____

Signature _____

Name _____

Home Phone _____

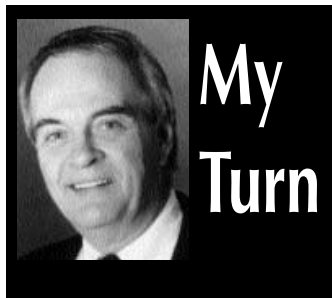
Address _____

City • State • Zip _____

Mail or fax completed form to The Heartland Institute,

19 South LaSalle, Suite 903, Chicago, Illinois 60603

fax 317/377-5000 (credit card orders only)



Wrong Prescription for High Drug Prices

BY CONRAD F. MEIER
MANAGING EDITOR

One of the Clinton-Gore administration's final acts before leaving office was to launch a campaign to demonize the nation's pharmaceutical industry. Although the industry's products are responsible for nearly doubling human life expectancy during the twentieth century, a posse of government regulators, "public interest" advocates, and trial lawyers was assembled to accuse the industry of charging too much for its products.

Even today, the anti-pharmaceutical industry campaign is going strong. In Illinois, the campaign has taken the form of two recently introduced bills, HB 2470 and HB 2236, that would force pharmaceutical manufacturers to sell their products at steep discounts in order to remain eligible to participate in state Medicaid programs.

House Bill 2470, sponsored by State Representatives Jack Franks (D-Woodstock), Jay Hoffman (D-Collinsville), and 39 cosponsors, and the Senate version sponsored by Senator Ira Silverstein (D-Chicago), amend the Illinois Public Aid Code to expand the number of

senior citizens eligible for discounted drug prices based on the Medicaid reimbursement rate. The bill requires pharmacies to implement the drug discount rules as a condition of doing business in the Illinois Medicaid program.

House Bill 2236, also sponsored in the House by Franks, Hoffman, and 60 cosponsors, and by Silverstein in the Senate, creates the Senior Citizen Discount Program Act, which would enable eligible seniors to buy prescription medication at discounted prices if they pay an annual premium into the program. It also would allow the state to "negotiate" rebates with drug manufacturers in an effort to reimburse pharmacies for the cost of providing the Medicaid discount. In other words, the state would extort from drug manufacturers the money needed to subsidize lower drug prices.

What's wrong with these attempts to help seniors save money on their prescription bills? Plenty.

Workability, Constitutionality Questioned

Price controls and forced rebates create an unsustainable market price below the level consumers are willing to pay. In every industry where they have been tried, price controls have discouraged investment in research and development, risk-taking, and marketing. If applied to the pharmaceutical industry, price controls would result in fewer life-saving and pain-relieving drugs in the future.

American drug manufacturers lead the world in discovering, testing, and introducing new drugs, but their leadership comes at a price: They must be allowed to charge "what the market will bear" for the newest drugs on the market. Competition among major drug manufacturers, not government regulation, is the only way to limit prescription drug prices without harming consumers.

Price controls and rebates are also

probably unconstitutional. The chief judge of the federal district court in Maine, D. Brock Hornby, accepted that argument in ruling on Maine legislation similar to the Illinois bills. Hornby rejected a part of the Maine program that required drug companies to subsidize discounts extorted by the state. By demanding rebates on drugs sold to wholesalers and distributors in transactions consummated outside the state, Hornby said, Maine was interfering with interstate commerce, in violation of the Constitution.

"According to the Health Care Financing Administration (HCFA), over 65 percent of seniors already have some form of insurance or other financial support to pay for their prescribed medications, and another 30 percent have little or no need for medication."

Dangers of Too-Easy Drug Access

Price controls and rebates artificially inflate demand for prescription drugs by insulating customers from the true cost of the drugs they choose to buy. In the case of senior citizens, many of whom take multiple prescription drugs, too-easy access poses a genuine threat to public health.

Drs. Michael Arnold Glueck and Robert J. Cihak point out that 10 to 20 percent of hospitalizations of seniors are the result of drug side effects and unexpected interactions. According to Glueck and Cihak, "No physician can completely understand all the interactions possible when multiple drugs are used." A "free" prescription drug benefit will compound what is already a growing public health problem. (See "Unlimited Prescription Drug Coverage May Endanger Seniors," *Health Care News*, March 2001.)

Finally, HB 2470 and HB 2236 would disrupt an entire industry to benefit only a few. According to the Health Care Financing Administration (HCFA), over 65 percent of seniors already have some form of insurance or other financial support to pay for their prescribed medications, and another 30 percent have little or no need for medication or for other reasons are not financially affected by current pricing practices.

Some of the remaining 5 percent of uninsured seniors with significant drug costs may need help, but that does not require undermining the quality of service received by the other 95 percent. Missouri and Michigan, for example, have addressed the problem by creating

'Tis the Season

A review by Assistant Editor Greg Scandlen of upcoming health care conferences

July 12-13

Global Business Research is sponsoring a conference in Chicago on July 12-13, addressing the topic "Consumer-Driven & Defined Contribution Healthcare." There will be sessions on employee empowerment, actuarial issues, risk-based rating, legal and tax issues, and case studies. Registration is \$1,495. Further information is available on the Internet at <http://www.globalbusiness-research.com>.

July 23-24

The Institute for International Research is also sponsoring a conference in Chicago on "Consumer-Driven Healthcare and Defined Contribution" on July 23-24. This one costs \$1,595 for a day-and-a-half, or \$1,995 if you include another half-day workshop. This conference will also include case studies and information on e-commerce, legal issues, and emerging models. Detailed information is available at <http://www.iir-ny.com>.

July 31

The Cato Institute is holding a day-long conference on "Making a Federal Case Out of Health Care: Five Years of HIPAA," on July 31. Majority Leader Dick Armey (R-Texas) is the keynote, to be followed by sessions on: The Price of Portability Promises; Health Privacy; The Beginning of the End or the End of the Beginning?; Criminalization of Medical Practice; and Reassessing Incremental Health Regulation. The program will be held in the Hayek Auditorium at Cato's headquarters in Washington. Registration is free. For more information see <http://www.cato.org/events/hipaa/schedule.html>.

tax credits for seniors to offset the amounts spent on prescriptions. President George W. Bush's pharmaceutical drug proposal also uses tax credits.

Another workable alternative would be for Illinois legislators to give seniors tax credits equal to the premium of a Medigap Supplement Insurance policy rich in prescription benefits. State officials could negotiate with the state's largest provider of Medigap policies—Blue Cross/Blue Shield—to develop a plan that uses its market power to buy drugs and sell them to the Medigap policyholders. A similar plan in North Carolina has saved seniors \$10 million since its inception in 1998. Colorado, too, recently passed legislation using free-market alternatives to price controls and forced rebates.

This approach, combined with the federal tax credits, will better serve the needs of senior citizens than the medicine maze currently being assembled by Illinois legislators.

A Word to Our Readers

Please check your mailing label!

If we've misspelled your name or have an incorrect address, please let us know so we can correct our records! Address corrections can be faxed to **312/377-5000**, emailed to **lvankinscott@heartland.org**, or mailed to The Heartland Institute, 19 South LaSalle Street #903, Chicago, IL 60603.

www.heartland.org

Help us build a grassroots movement for market-based health care reform!

Please complete and return one of the cards below to receive *Health Care News* for free for one year. Urge your friends and colleagues to fill out the other forms!

Return this form today for a FREE subscription to Health Care News!

Please check ONLY ONE section:

HEALTH CARE PROFESSIONALS

Are you a:

- ☐ Doctor
- ☐ Nurse
- ☐ Insurance broker
- ☐ Pharmacist
- ☐ Hospital administrator
- ☐ Insurance industry professional
- ☐ Pharmaceutical industry professional
- ☐ Managed care professional
- ☐ Other: Specify _____

PUBLIC OFFICIALS

Were you:

- ☐ Elected
- ☐ Appointed

At what level of government:

- ☐ Federal
- ☐ State
- ☐ County or local

REFORM ACTIVISTS

Which best describes your role in the health care reform movement?

- ☐ Doctors' rights advocate
- ☐ Patients' rights advocate
- ☐ Taxpayers' rights advocate
- ☐ Employers' rights advocate
- ☐ Other: Specify _____

MEDIA

- ☐ Health care reporter/writer
 - ☐ Print
 - ☐ Electronic
- ☐ Other
 - ☐ Print
 - ☐ Electronic

BUSINESS

- ☐ For-profit company
- ☐ Non-profit company
- ☐ Trade association
- ☐ Chamber of commerce or similar organization

Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here _____

Signature Required Below



Name _____
Title _____
Business _____
Street _____
City/State/Zip _____
Phone Number _____

Return this form today for a FREE subscription to Health Care News!

Please check ONLY ONE section:

HEALTH CARE PROFESSIONALS

Are you a:

- ☐ Doctor
- ☐ Nurse
- ☐ Insurance broker
- ☐ Pharmacist
- ☐ Hospital administrator
- ☐ Insurance industry professional
- ☐ Pharmaceutical industry professional
- ☐ Managed care professional
- ☐ Other: Specify _____

PUBLIC OFFICIALS

Were you:

- ☐ Elected
- ☐ Appointed

At what level of government:

- ☐ Federal
- ☐ State
- ☐ County or local

REFORM ACTIVISTS

Which best describes your role in the health care reform movement?

- ☐ Doctors' rights advocate
- ☐ Patients' rights advocate
- ☐ Taxpayers' rights advocate
- ☐ Employers' rights advocate
- ☐ Other: Specify _____

MEDIA

- ☐ Health care reporter/writer
 - ☐ Print
 - ☐ Electronic
- ☐ Other
 - ☐ Print
 - ☐ Electronic

BUSINESS

- ☐ For-profit company
- ☐ Non-profit company
- ☐ Trade association
- ☐ Chamber of commerce or similar organization

Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here _____

Signature Required Below



Name _____
Title _____
Business _____
Street _____
City/State/Zip _____
Phone Number _____

Return this form today for a FREE subscription to Health Care News!

Please check ONLY ONE section:

HEALTH CARE PROFESSIONALS

Are you a:

- ☐ Doctor
- ☐ Nurse
- ☐ Insurance broker
- ☐ Pharmacist
- ☐ Hospital administrator
- ☐ Insurance industry professional
- ☐ Pharmaceutical industry professional
- ☐ Managed care professional
- ☐ Other: Specify _____

PUBLIC OFFICIALS

Were you:

- ☐ Elected
- ☐ Appointed

At what level of government:

- ☐ Federal
- ☐ State
- ☐ County or local

REFORM ACTIVISTS

Which best describes your role in the health care reform movement?

- ☐ Doctors' rights advocate
- ☐ Patients' rights advocate
- ☐ Taxpayers' rights advocate
- ☐ Employers' rights advocate
- ☐ Other: Specify _____

MEDIA

- ☐ Health care reporter/writer
 - ☐ Print
 - ☐ Electronic
- ☐ Other
 - ☐ Print
 - ☐ Electronic

BUSINESS

- ☐ For-profit company
- ☐ Non-profit company
- ☐ Trade association
- ☐ Chamber of commerce or similar organization

Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here _____

Signature Required Below



Name _____
Title _____
Business _____
Street _____
City/State/Zip _____
Phone Number _____

School Reform News

Environment & Climate News

Intellectual Ammunition

PolicyBot

The Heartlander

Heartland.org

HotDocs

SchoolReformers.com

Activist Toolbox

ClimateSearch.com

Issue Suites

Visit Heartland.org for the latest information on health care policy... and a whole lot more.

PolicyBot pairs the Internet's largest collection of free-market public policy research and commentary with a fast, user-friendly search engine. **Nearly 7,000 documents on a wide range of topics are available for free.** Sign up for HotDoc's free daily or weekly reports, sent by email, on new research available. Visit www.heartland.org and click on the *PolicyBot* icon.

For the best available research and commentary on the science, economics, and politics of environmentalism, visit www.heartland.org and click through to the **Common-Sense Environmentalism's Suite**. Or view back issues of *Environment & Climate News* at www.heartland.org/environment/whatis.htm.



SchoolReformers.com offers extensive coverage of the school reform movement and a wealth of research, commentary, model legislation, contacts, and tools for grassroots activists. Click on the SchoolReformers.com icon at www.heartland.org, or go directly to www.SchoolReformers.com. And get the complete text of back issues of *School Reform News* at www.heartland.org/education/whatis.htm.

Check out the **Activist's Toolbox** on the www.heartland.org home page for comprehensive directories of experts, think tanks, media contacts, and elected officials, as well as the American Legislative Exchange Council's complete sourcebook of model legislation.

The complete texts of over 1,000 documents addressing the science, politics, and economics of global warming are available at **ClimateSearch.com**. Click on the ClimateSearch icon at www.heartland.org or go directly to www.ClimateSearch.com.

Join us! Become a member of The Heartland Institute for as little as \$29 a year. Members get free subscriptions to publications including the monthly *Heartlander*, as well as free copies of books, policy studies, and more. Go to www.heartland.org and click on **Membership**.

The Heartland Institute
The power of ideas